

HEALTH CARE REFORM: IMPLICATIONS FOR SENIORS

Y 4. AG 4: S. HRG. 103-740

Health Care Reform: Implications fo...

HEARING
BEFORE THE
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE
ONE HUNDRED THIRD CONGRESS
SECOND SESSION

LANSING, MICHIGAN

MAY 18, 1994

Serial No. 103-21

Printed for the use of the Special Committee on Aging



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HEALTH CARE REFORM: IMPLICATIONS FOR SENIORS

WEDNESDAY, MAY 18, 1994

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Lansing, MI.

The Committee met, pursuant to notice, at 10 a.m. at Lansing Center, 333 East Michigan Avenue, Lansing, Michigan. Hon. Don Riegle (acting chairman of the Committee) presiding.

Present: Senator Riegle.

Staff present: John Sciamanna and Elizabeth Gertz.

OPENING STATEMENT OF SENATOR DONALD W. RIEGLE, JR., ACTING CHAIRMAN

Senator RIEGLE. The Committee meeting will come to order. I want to welcome all those in attendance this morning. We're going to continue to have people coming in from downstairs, but I want to start because we have a number of important witnesses to hear from this morning.

This is an especially meaningful and important health reform hearing today with its potential impact on seniors. And I want to thank The Board of Senior Power Day for their leadership in helping us to put this together.

I don't know if you can hear well enough in the back of the room. I'll try to speak right into this microphone because you're never sure in these rooms how the sound works.

This is a hearing of the U.S. Senate Special Committee on Aging. And our hearing as part of Senior Power Day has been officially recognized by the White House Conference on Aging, so our hearing today will be a part of the official conference record when it convenes next spring in Washington, D.C. for the White House Conference.

Those of you who were downstairs and had a chance to hear Hillary Clinton speak to us just a few minutes ago know from that appearance and also from all the other things that have happened, the very strong commitment that the President and the First Lady have made to this health care reform issue.

Within that issue, there are a number of absolutely critical issues that affect seniors. Certainly the prescription drug question, home health care, the issue of having health insurance for early retirees, a group that's growing in our country, a very significant group here in Michigan.

Many times people who are not old enough to qualify for Medicare have ended their work careers, may not be able to work, or

may not be able to find work. Private insurance is prohibitively expensive for many of them.

Many of them do not have carry over insurance from their earlier employment and so they're just out there in a very difficult situation until they finally reach Medicare age.

These are problems that are dealt with in the health care proposal that the President has put forward and it's something that I think we have to make sure we get accomplished this year.

It was 60 years ago that we initiated Social Security and thank God we did because imagine where we would be today without it. And then 30 years later, we had the advance of Medicare. And you might think about where we would be today without Medicare.

I know I've gone through this situation of losing both my parents in the last 2 years. And both involved—in one case, my father's several weeks in the hospital, as he was trying to recover and we were hoping perhaps he could recover.

But as I was there with him and seeing so many other families that I've known over the years in my hometown of Flint, I've seen there, as I have all across the State of Michigan, the tremendous situations that arise within families, not just when people are senior age, of all ages, but very particularly at that age. And these are issues that have to be dealt with in this health care reform package.

You should know that in Michigan today we have fully 1 million adults who have no health insurance. In some respects, even worse than that, we have 300,000 Michigan children today who have no health insurance.

We're not talking about Bangladesh or South Africa or some other country that is thought of as an underdeveloped country. We're talking about our own country and we're talking about our own State.

There are people in this room and within walking distance of this room who have no health insurance at the present time, can't afford to buy it or even if they have some money to buy it, the insurance companies don't want them because they may have a pre-existing condition or their profile would cause the insurance company to say, "Well, we don't want to insure that person because they might have a claim on the policy." These things need to change.

There's a lot in our health care system that works well and works properly and we want to keep those things. The parts that are not working well or that need to be reengineered, for example, a common insurance form and some of the other kinds of things are changes that it's time to make.

I want to now zero in on three issues that relate directly to seniors and to early retirees. I want to talk first in reference to this chart about what has happened to drug prices, prescription drug prices in the United States just since 1980.

And if you see over on the left side of this chart, if you look at the general inflation since 1980 up to the present time of all the other goods that one buys in the society, the inflation over that period of time, some 13 years, has been 48.6 percent.

But if you take a look over here in the red area, 216.4 percent is the price inflation on prescription drugs since 1980.

And you look at the difference here and you say to yourself, "Why is it that we're seeing this kind of tremendous price inflation on prescription drugs and yet every other item in our entire economy is showing a substantially lower inflation rate?"

Now, some of that may be justified with new research. A lot of it, I think, is not justified. But the simple fact is, if you need medicine to stay alive or to stay out of the hospital or stay out of a nursing home and you don't have the money to pay for these prescription drugs, then you're in an impossible situation.

And we need to solve that problem. Because by solving it, we're going to save money and we're going to help people.

Now, there are going to be some people who say, "Well, no, that's not right." In fact, even some of the drug companies. You'd think they'd want a prescription drug benefit. Some do; some don't. Some of the ones that don't are concerned that it's going to bring too much attention to price inflation.

I think the bottom line that seniors and thoughtful citizens should insist on is we need to have a prescription drug benefit in this health care reform program so that people don't have to go hungry or they don't have to be in a situation where they can't heat their house properly in the wintertime because they're having to take the money to buy the medicine to stay out of the hospital or the nursing home.

Now that's a problem we can fix and we ought to fix it in this plan.

Let me mention another one. Long-term care. We know that in many cases home health care can work for many people for a long time.

My mother was a fiercely independent woman and she was a diabetic so she needed certain kinds of home health care, but the last thing in the world she wanted to do is go to a nursing home. So she insisted that she stay in her house as long as she possibly could.

But I've seen in that case and hundreds and thousands of other cases in Michigan that if we can have home health care and some long-term care support of the kind that's needed in the given situation, we can substantially improve the quality of life for that person, for the rest of their family, and in the end, we can save money.

What we should not have is a situation where if a person needs long-term care, they have to go on public assistance in order to get it.

The way the system works now is that you spend down your assets, and divest yourself of your life savings—it doesn't take long if you're in a nursing home. With nursing home costs per month these days, you can whittle away a whole lifetime of savings in nothing flat.

Then the issue is you've got to impoverish yourself and go on public assistance and qualify for Medicaid to be able to get that kind of help.

Now, why do we want to have American citizens put in that situation in order to get the help that they need to have? Why do we do that to ourselves?

There's no sense in that and there's no real justice or decency in it and we need to change it. And this is still a government of the

people and we have the power to make these changes and we ought to make them right now before any other people get caught in this situation, have their lives ground up because the way the system is working, because the system isn't working properly.

Another thing that I want to mention is this: The early retirees, I touched on it a minute ago, we've got a lot of early retirees in this State; some had to retire because of health considerations, some had to retire because their jobs disappeared and went to Mexico or to Japan or some other place.

Many times people who are out younger than 65 or younger than 62 cannot find alternate work or their health won't permit them to be able to work and that's the box they're in, if they don't have carry over insurance from their previous employment and most don't.

Now, we're fortunate for the auto retirees that they do, but most retirees do not. And they can be in a situation where they're without health coverage and the insurance companies don't want them. Or if they want them, they want them at a rate that nobody can afford to pay. Well, we can't have that.

We ought to be organizing the insurance companies and the insurance system so it helps the people. There's a way to do this and still earn a return on capital and a fair profit and do it in a way that doesn't cause people to have their lives ripped apart.

So if you take an early retiree who is in their late 50's, maybe they have a health problem, maybe they have a diabetic condition or something else of that kind, we have to be sure that they have access to affordable insurance, health insurance protection and it's going to provide what they need.

And I'll tell you this, my 28 years in the Congress, I've seen us build enough high cost items, nuclear warheads, bombers, battle-ships, all kinds of things.

We've got a lot of veterans in this room today who over the years served and have seen how we spend our money on the weapon's side of our national defense effort.

Well, part of our national defense has to be to look after the health of our people. And the point is, we've got the resources to do this if we're intelligent about how we engineer the system.

And it's significant that every other country in the world, every other advanced country in the world now has—one form or another of health care where they get health care coverage to everybody and it costs them less than it's costing us and we still have 40 million people left out of the system, including a million here in Michigan.

But importantly in the senior group, we've got to pick up these early retirees who cannot work in many cases and who can't get in health insurance coverage and who have to have health insurance coverage and shouldn't have to become poverty cases or homeless people in order to try to get the money they need just to hold body and soul together.

So that's why we have government in America. Some people can say, "Well, maybe I don't like the government." Well, the government is us and it ought to do what we think should be done.

In the area of health care, if we don't have an encompassing system that's fair and efficient and that sees to it that we get the care

we need, what's going to happen is you're going to have a lot more heartache and suffering and it's going to end up costing us more at the same time.

Well, we're too smart for that and we ought to be too humane for that to settle for that kind of a situation. So this is the year to try to get it changed and get it done.

I've said enough. I want to introduce our first panel who are here today. I want you to hand up questions that you may have, too, in the course of our hearing this morning. And if time permits, after we've heard from our witnesses, we'll try to take some of those questions.

Our first panel is consisting of individuals and families who are experiencing real tough problems with the current health care system.

I'm going to introduce each one—one is going to get a special introduction from the table—then we'll hear a summary from each of them on what their problems are and some ideas as to how we might go about addressing and fixing those problems.

Carol Chapman is a 63-year-old uninsured woman from Rogers City. She is currently suffering from Graves disease which has caused her eyesight to deteriorate badly.

She applied for Medicaid and was denied the coverage. She is not yet eligible for Medicare. And she's going to discuss with us the high cost of health care for uninsured people in a situation such as she is facing.

Then we're going to hear from Orville LaGuire who is from here in Lansing who's going to talk about prescription drug and medical costs. Orville is going to be introduced by Kate Carr who is the wife of Congressman Bob Carr whose district covers this Lansing area.

And Bob Carr is also a member of the Michigan Senior Power Day Board. His office was instrumental in securing Orville as a witness for us today.

Then next you'll hear from Lisa Minott who is from Kalamazoo. She is the primary caregiver for her elderly and disabled mother Margaret who is 69 years old and suffers from Parkinson's disease.

Lisa's going to talk about the demands that fall on her because there is no national long-term health care program for folks like her mom.

And then finally we're going to hear from Debbie and Rick Arnold who live in Pontiac. Their son Christopher suffers from an immune deficiency disorder which has resulted in very expensive medications and surgery.

The family health plan does not fully cover the costs of their son's need. And they're here to talk about the current health care situation that they're up against like so many others.

So we'll start with Carol Chapman.

[The prepared statement of Senator Riegler follows:]

PREPARED STATEMENT OF SENATOR DONALD W. RIEGLE, JR.

Welcome to this important hearing on health care reform and its potential impact on seniors. I would like to thank the board of Senior Power Day for being a valuable resource in putting this event together.

This gathering marks the 20th anniversary of the Senior Power Day event, and I want to congratulate all the members of this organization for your dedication and hard work over the years. The Senior Power Day Organization have not only made

a difference for seniors but, through your efforts on such issues as universal health coverage, you are making a difference for all the people of Michigan.

This hearing of the U.S. Senate Special Committee on Aging has been officially recognized by the White House Conference on Aging. As such it will be part of the official Conference record when it convenes next spring in Washington, D.C.

President Clinton and Mrs. Clinton have shown great leadership in bringing this issue to the political forefront. Mrs. Clinton joined us by satellite earlier today.

There is growing consensus that a health care reform plan must be hammered out and adopted—just as Social Security was nearly 60 years ago and Medicare some 30 years later. To develop that consensus on health care reform I have held close to 40 public hearings and forums across Michigan and in Washington to gather all the facts, consider our options and build public support for a comprehensive overhaul of our system. This hearing continues the process. As Chairman of the Subcommittee on Health for Families and the Uninsured and a member of the Committee on Aging, I will continue to solicit the views of Michigan citizens to make sure the final plan addresses the unique health care needs of our state.

With leadership from the White House, the time has finally come to take action. It is time to provide health care coverage to the 1 million people and 300,000 children in Michigan who do not have insurance. It is time to provide health security to people who fear losing their coverage because of rising costs or pre-existing conditions. And it is time to provide prescription drug and home health coverage to senior citizens in need.

Quality, affordable health care coverage needs to be available to all Americans always. A critical part of this is getting health care cost under control. In the United States we spend more than any other nation, but we don't cover everyone and we do not have the best health outcomes. Every year costs go up and so does the number of uninsured. We need to make the systems more efficient.

In reforming the Nation's health care system we need to keep what works and fix what's broken. The Medicare program has served seniors well and it must continue to provide access to the highest quality of care. Health care reform should also serve as an opportunity to address some of the health care problems still facing older Americans. These include: prescription drugs coverage, long-term care, and gaps in health care coverage for early retirees. These concerns and others are detailed in the Senior Power Day Platform, and ask that this resolution be included in the hearing record.

The importance of prescription drug coverage cannot be overstated, and this is particularly true for senior citizens. A recent report by the AARP showed that nearly half of senior citizens have no prescription drug coverage. This has become an even greater problem as the cost of prescription drugs continues to soar. As we can see from Chart I, since 1980 drug prices have increased four and one-half times greater than general inflation. These costs hit seniors particularly hard because they take more than three times as many prescription drugs as the rest of the population. In fact, prescription drugs are the highest medical costs for 3 out of 4 Medicare beneficiaries.

We also need to address the issue of long term care coverage. Over the course of our lives, the need for long-term care will touch most if not all of us in some form. I am particularly concerned that people receive care in the setting which is most appropriate for them, whether it is in their home or in a long-term care facility. As we can see from Chart II, we spend a lot more money on nursing home care—\$53.1 billion, than we do on home health care—\$6.9 billion. There is a clear bias toward nursing homes which is taking choice away from seniors.

This chart also shows that the majority of money for nursing home care comes mainly from two sources—families in the form of out-of-pocket costs and the Medicaid low income program. So if you or a family member needs nursing home care, there is a good chance you will have to spend all your assets to qualify for Medicaid.

Another important issue is the treatment of early retirees—people not working and between the ages of 55 and 65. As we can see from Chart III this group, like people over 65, are a growing portion of the population. These people, who are not yet eligible for Medicare, are being particularly hurt by the current health care system. They have trouble getting affordable care. About 2.7 million Americans between age 55 and 65 have no health insurance at all. Early retirees have more health care needs than younger populations, they are often on fixed incomes, and have limited work options.

I will be working hard in the Senate to come up with a plan that guarantees universal coverage, and address each of these important concerns. The Senate Finance Committee, of which I am a member, is just completing a series of health care reform hearings. In these next few weeks we will be meeting to put together a Finance Committee version of health care reform. We hope to report a bill to the Sen-

ate by the end of the month or in early June. A similar process is going on in the Senate Labor and Human Resources Committee as well as in several committees in the House of Representatives. This is an ambitious schedule, but it's one we need to stick to in order to pass a bill this year.

In an effort to put a human face on the health care crisis, each week I speak on the Senate floor about a different Michigan family's tragic experience with the health care system. So far I have described the health care difficulties faced by 51 of Michigan's individuals and families. Three of these family members are here today to testify. They and several other witnesses will speak from first hand experience about some of the problems with the current health care system, and several experts who can provide us with additional insights. Let's begin with the first panel.

**Drug Inflation Increased
Four and One-Half times
General Inflation
1980 - 1993**



**General Inflation
(PPI)**

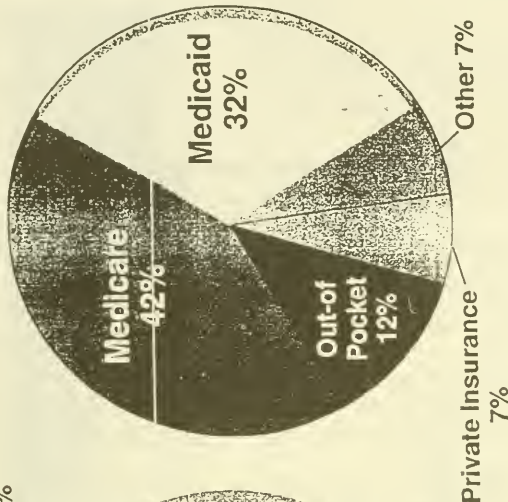
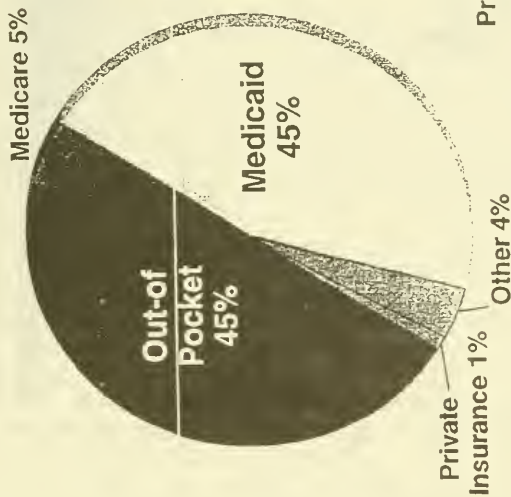


**Drug Inflation
(PPI - Rx)**

Source : Bureau of Labor Statistics

PPI = Producer Price Index, which measures
inflation at manufacturers' level

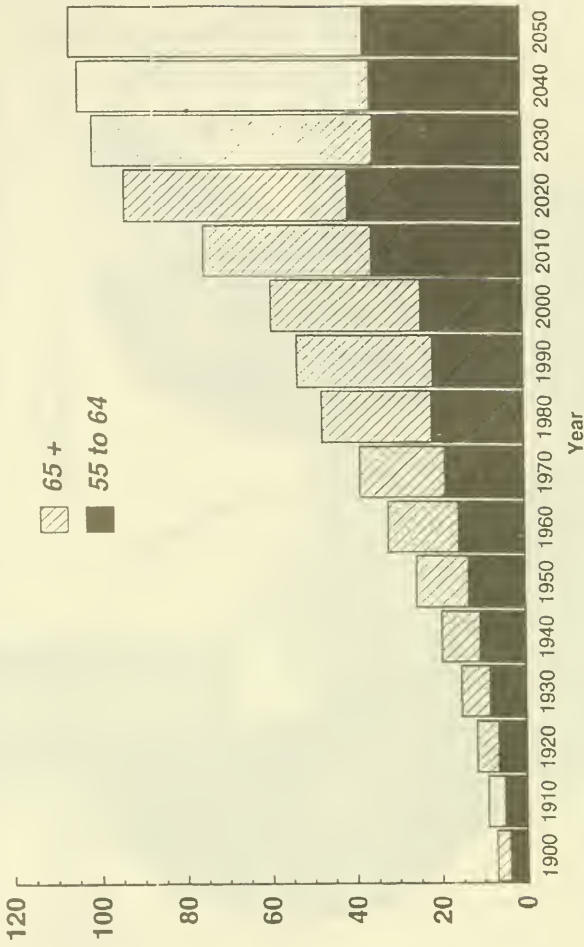
Sources of Long-Term Care Funding, 1990



Source: Levit et al, 1991

Population Age 55 +, by Age Group: 1900-2050

(IN MILLIONS)



Sources: Decennial Censuses of the Population, Current Population Reports Series P-25, No. 1018 (January 1989)

STATEMENT OF CAROL CHAPMAN, ROGERS CITY, MI

Ms. CHAPMAN. Okay. Thank you. Your Honorable Senator Rieggle, panel members and guests, I would like to introduce myself and tell you about my life for the past year.

My name is Carol Chapman. I am 62, will be 63 in August.

Senator RIEGPLE. I'm sorry. I gave you—I celebrated your birthday a little early. I didn't mean to do that. That's a sensitive issue. I apologize for that.

Ms. CHAPMAN. Okay. I am a 62-year-old female who is experiencing a life threatening disease without medical insurance. I am not old enough for the coverage by Medicare and I have applied and have been denied Medicaid.

In January 1993, I went to see Dr. Susan Howard, my family doctor, because I was not feeling well. Dr. Howard gave me a complete physical, including blood work. And the blood tests indicated arthritis and thyroid problems. I was not prescribed any medication at this time.

At this time I was working as a private pay provider for an elderly lady and it seemed as though I was getting sicker every day. I was experiencing diarrhea, nausea, rapid heart rate, and was very weak and shaky.

In April 1993, I went back to Dr. Howard because I had lost 30 pounds and was losing muscle ability in my arms and legs. Dr. Howard ran more tests, which indicated that I had hyperthyroid goiter problems and was referred to Dr. Britten, a local surgeon.

Dr. Britten felt that the problem could be treated with medication. But to be on the safe side, he referred me to Dr. Chavarri who treats thyroid problems and Dr. Chavarri just diagnosed my problem as Graves disease and prescribed the following medication.

I can't pronounce the word so I'll call it PTU, 50 milligrams, three tablets every 8 hours; Enderal, 20 milligrams, one tablet every 8 hours; Procardia, 60 milligrams, one tablet daily; Dyazide, one tablet daily; and Ativan, 1 milligram, two tablets daily; Biaxin, 500 milligrams, two tablets daily, that's just for 14 days and that's for my sinus infection; Extra Strength Tylenol, I just take that for my arthritis problem, and I take that twice daily.

In September 1993, the Graves disease began to affect my eyesight. I was experiencing double vision, light sensitivity, and a constant feeling that I had sand in my eyes.

Dr. Chavarri referred me to Dr. Currier, a local ophthalmologist who examined me and determined that there was no medical explanation for my symptoms.

Again, I explained to Dr. Chavarri the problem I was experiencing with my eyes. He then referred me to Dr. Frueh, an ophthalmologist at the University of Michigan Hospital in Ann Arbor.

On November 1, 1993, Dr. Frueh examined me and indicated that there was some decline in my left eye and prescribed a prism for my glasses and Tear Drops, eye drops, to soothe the scratchy feeling.

In January 1994 I returned to Dr. Frueh's office in Ann Arbor because the vision in my right eye was declining and I was experiencing extreme pain.

The doctor felt that I was experiencing excessive pressure on the optic nerve and required surgery. I was concerned about the sur-

gery because of the lack of medical insurance and began to contact service agencies for assistance.

I am currently receiving help from the Department of Education and Rehabilitation. And thank God for them.

I had the surgery on the 27th of April. However, Dr. Frueh is not happy with the results and I was——

Senator RIEGLE. Take your time. I know it's hard to talk about these things. Just take your time.

Ms. CHAPMAN. I was required to return to Ann Arbor for a field vision test on the 6th of May and he wasn't happy about that either.

Currently I am still taking all the medications and will return to Dr. Frueh's office in early September. I may also have to have surgery on the thyroid to have it removed.

In order to function as I did prior to the Graves disease, I require a talking clock that chimes the time, a large numbered phone, and a large faced watch. I rely totally on friends and family for all my transportation needs, shopping and doctor visits.

I have applied for Social Security disability. But at this time, I am not certain if it will be approved.

My past work record consists primarily of a provider for care of the elderly patients in nursing homes and adult homes, adult foster care homes. I am unable to work because I would not be able to drive. And when I got there, I wouldn't be able to administer medications or assist with ambulatory and general personal care and grooming.

I receive \$589 monthly from my deceased husband's Social Security. My monthly bills consist of prescribed drugs, \$108 a month; rent, \$131; car insurance, \$48, which I'm not able to drive; car payment, \$95, which I'm not able to drive anyway; utilities, \$40; cable TV, \$13; credit card, about \$70 a month; and a bank loan of about \$24 a month—a total of \$529.

The credit card is because I don't have the money to come down to Ann Arbor for my doctor visits. I also have outstanding doctor bills of approximately \$2,678.80.

In closing, I would only like to indicate that a round trip to and from Ann Arbor is 536 miles and the overnight stay runs \$47, which I have to pay myself and the transportation provider, transportation to each of the physicians I visit totally in a minimum of 90 miles a round trip.

I know that there are many people in the same situation. We all really need some type of insurance, even insurance that we could pay a small amount for each month would be a great benefit.

Thank you very much.

FOLLOWING ARE THE TOTALS OF MS. CHAPMAN'S BILLS AND RECEIPTS FOR:

(1) PRESCRIPTIONS FROM 1/94 TO 5/94; (2) DOCTOR BILLS 1994; (3) EXPENSES FOR GLASSES AND TRIP 1994; (4) HOSPITAL BILLS 1994; (5) PRESCRIPTIONS 1993; (6) DOCTOR BILLS 1993; AND (7) HOSPITAL BILLS 1993.

(COPIES OF THE ACTUAL BILLS ARE HELD IN COMMITTEE FILES.)

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1/94 - 5/94

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Dr. Bills
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Net pd. 442.00

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Dr. Bills
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Dr. Bill
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30.00 + ✓

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4.00 + ✓

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24.80 + ✓

29.60 + ✓

123.00 + ✓

20.00 + ✓

100.00 + ✓

27.20 + ✓

34.40 + ✓

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Senator RIEGLE. Thank you very much, Carol.

Carol, can I ask you just to stand up because people wanted to see you and they couldn't see you because you're seated and I'm going to bring everybody else up here to speak so they can be seen throughout the room. Would you just stand up so people can see you?

This is Carol right here.

Next we're going to have Orville LaGuire come up. Orville, do you want to come up and Kate, do you want to come on up, too, and sit here and I'm going to have all of our remaining witnesses on both sides come up here to speak so that you can see them as well as hear them. The nature of this room is such that it's a little hard to—I've already told you Orville's story and he'll elaborate on it. I want to now introduce Kate Carr, the wife of Congressman Bob Carr and she will make some introductory remarks because they helped us have Orville here today.

KATE CARR, REPRESENTING CONGRESSMAN BOB CARR

Ms. CARR. Thank you, Senator Riegle. On behalf of my husband, Bob Carr, I would first like to thank you very much for bringing this hearing, this very important hearing to our district here in Lansing, Michigan.

I know I speak for Bob when I say how much we appreciate your many years of dedicated service to the people of Michigan, particularly our senior citizens.

This testimony being given here today by our seniors clearly outlines why it is important and necessary that we reform our current health care system.

Bob has heard from seniors throughout his congressional district who are just trying to survive, seniors who are having to choose between either obtaining proper medical treatment, buying groceries, or paying the rent, while at the same time also trying to meet their other basic living expenses. They are doing all of this in most cases on very limited fixed income.

It is a travesty in America when our older Americans at a point in their lives when choices should be easier, are now being forced in their later years to have to make such tough choices. They deserve better than this.

I appreciate the opportunity to introduce your next witness, Mr. Al LaGuire, a local Lansing resident who's graciously agreed to testify before this Committee today because of his belief that an awareness of the problems being faced by older Americans must be heard.

Mr. LaGuire, on behalf of Congressman Carr, thank you for agreeing to come here today to share your personal situation. I know it will be helpful in raising public awareness to the plight being faced by many of our citizens.

Thank you.

Senator RIEGLE. Now, let me urge you to get just as close to this as you can and that will help you to be heard by the fellow in the back row who wants to hear everything you have to say.

STATEMENT OF ORVILLE "AL" LA GUIRE, LANSING, MI

Mr. LAGUIRE. Good morning. My name is Orville "Al" LaGuire and I live at 4201 Wainwright in Lansing. I've lived there for some 40 years.

Thank you for allowing me to testify before the Committee today to tell you about my personal and very recent experience in the medical field and my problems with obtaining prescription drugs.

And I'm partly here because this was so immediate, it's in the immediate past, and it came home very dramatically to me as you'll see what we're dealing with here.

I'm a retired person on Medicare. I like to call myself just Citizen LaGuire. And I'm a concerned citizen on this issue.

I have been kind of fighting a battle of survival against various diseases for many years and I've had good luck. I've had eight surgeries in the past 15 years. My most recent was ear tumor radiation in Chicago earlier this month and this is my current medical problem.

Now, this hearing, Senator, is a chance for me to say thank you to the system and I want to express gratitude. Medicare, which I did come under when I retired fortunately, has saved my skin numerous times. If I may on the transcript, somebody had written in "save my soul", could we amend that, sir?

Senator RIEGLE. Yes.

Mr. LAGUIRE. To read skin? I mean, it would be nice if Medicare would—

Senator RIEGLE. You're in charge of saving your soul. Medicare will save your skin.

Mr. LAGUIRE. Let's not ask the government for too much.

Senator RIEGLE. Yes.

Mr. LAGUIRE. So anyway, I'm not here to complain but rather to express gratitude, believe me. And particularly if my experience will be of help for correcting other people's problems in obtaining prescription medicine, on that one alone, I'm only too glad to do it now.

My most recent experience was in the first 2 weeks of May—okay, I chose radiation so I wouldn't have to go through another regular surgery, which I did not know how well I might stand it.

I went to Chicago to get this particular type of cobalt treatment for the tumor inside the head which is an excellent facility down the way. And I could avoid an 8-day hospital stay and get it done in 3 days.

I saw that that would not only make it easier on my somewhat battered body but would save money for both me and the Medicare system, which I've been a big drawer upon, see.

The acoustic Neuroma, the only symptom was a ringing in my ear about a year ago and I noticed then my hearing was going down and down and asking my wife and everybody to repeat this and repeat that. And I figured, that goes with the territory of aging, it didn't bother me that much.

Finally went to the doctor to check it. He started checking it out, and the third ear specialist sent me to the MRI and then they spotted the tumor inside the ear canal and something has to be done about that because it can grow in toward the brain stem—40 per-

cent of my hearing was gone in my right ear and since—I should be more conscious of everybody else here then too?

Senator RIEGLE. That's right.

Mr. LAGUIRE. Since then, I've been to a number of different doctors, 12 within 1 week, the various specialists, to help me out. Some were called in as consultants right there in Chicago.

The point is, that the regular surgery would have taken me at least 8 days hospital at those costs; the radiation only 3 days.

So going into January, I had no idea that my ears were even getting bad. This was a totally new surprise. Or that I needed assistance on that medical problem.

Now, one of my main concerns is, like I say, this brought it right home to me, is how many of my countrymen and countrywomen are in that same boat and that boat is sinking. All of a sudden you realize you've got a torpedo.

I had radiation treatment on May 5th, 6th, and 7th, actually just 1 day treatment, May 6th at the Chicago Institute of Neurosurgery. My travel expenses, my share to Chicago, a little over \$200.

Radiation therapy was done on the acoustic tumor May 6th. I spent 2 nights in the hospital and was put on a very heavy medication schedule. The acoustic tumor radiation took about 1 hour.

For follow-up, I will need an MRI 1 month after that procedure and then 3 months after the procedure. These MRIs cost about \$2,000 a throw, I guess.

The reaction of the prescription steroid has been difficult, you know. My legs are swollen from my ankles to my waist and I've gained 15 pounds in 5 days. I'm ready for football or something. Can't sleep, have a huge appetite and bad restlessness.

This is the secondary result of the medicine but you have to take the medicine, the post-surgical thing. So they sent me home with 10 different prescriptions from Illinois.

I had to immediately—it would have been Saturday night—refill the prescriptions in Lansing. They gave me just enough at the hospital to get me overnight. Lo and behold, what did Al discover when he gets here with his Illinois prescriptions?

Michigan druggists cannot fill out-of-State prescriptions. What a spot to be in, immense problem. They also had to prescribe two or three other prescriptions to counteract the main one.

The receipts from the drugstore, which I have here as documents if you wish to have them into the record, 1 week added up to \$250 worth of prescription drugs just on this one experience here.

Anyway, I give great thanks to a local pharmacist who saw the problem and supplied me with four tablets overnight until I could get to my own local doctor here and get the Chicago doctor's prescriptions ratified, and have them filled in Michigan.

I brought this to the attention of Representative Byrum as a State problem basically, I guess. But it is a problem in the sense that I understand they're trying to keep illicit drug prescriptions out, but when a person needs them, he can be in a pretty tight spot.

So I spent money going to Chicago to avoid major incisionary surgery, avoid a general anesthetic and to save some money for myself and the system.

I pay \$103 Medicare supplement insurance premium out of my pocket every month, a very good Medigap policy; \$47 for Part B Medicare is taken from my Social Security.

I paid over \$500 in medical expenses just for the month of May, now, for this one thing. On a monthly income of—well, after that \$40 is out, \$882 Social Security, my small pension from my TIAA thing pays me \$220 a month and I do buy regular medicine continuously for another condition called Crohn's disease; average of \$50 a month, right along.

So my total monthly income is in the neighborhood of \$1,100—it says \$1,000, but there's a little bit more in there. Out of my total of \$1,100 monthly, in the month of May I spent \$650 on health care. Now, the balance left there had to go for everything else.

Now, fortunately my wife works part time out of necessity, obviously. I have obviously less than \$500 left to pay for everything else. We will manage and be okay. We are the type that we want to carry our weight just as long as we possibly can.

Her employment offers no health insurance whatsoever. She pays an additional \$170 per month for membership in an HMO because I could not carry her over on my former employer. So you can see what our total insurance and health costs are. And we're the lucky ones that had some fallback so——

Senator RIEGLE. Yes, right.

Mr. LAGUIRE. So it has struck me and believe me, Senator, with terrible force about how many other people deal with problems like this and it hits you like that and it brings it home.

My two sons who used to be here in Lansing live and work out in Hawaii. And despite the illness, my wife and I went out to visit them last year. I'm bringing this in, because I think it's pertinent to bring in my experience out there.

A recurrence of the Crohn's disease happened unfortunately on that vacation and I had to be hospitalized in Hilo for 10 days. This is an inflammatory bowel disease I've had for 30 years.

And this had previously caused me the total removal of the large bowel several years earlier. Now they have to go back in and resection to stop bleeding in the small one. So far, I've had four intestinal surgeries on the Crohn's disease.

And there are two things, the doctor fused me with emergency surgery, excellent care, by the way. Two things impressed me very much while I was there that I want to bring to the attention of the Committee.

I do not know the details or can be accurate of this, but I'm sure the Senator from Hawaii could tell you; anyway, they're on a system of universal coverage or pretty close in Hawaii.

Senator RIEGLE. That's right. They are.

Mr. LAGUIRE. Through where you work or if you don't work, special coverage. I think we ought to take a closer, closer look at that especially in Michigan.

People who live in Hawaii are either covered by their employer or a state-funded plan. This impressed me along with the quality of personal treatment accorded to me and my family.

My wife, I'm sure, would verify this while we were in Hilo Hospital, the Hawaiian hospitality was extended right in there.

And I will tell you this, I feel a little bit sentimental about this. It was necessary for me to draw 14 pints of transfusion in order to survive. So as far as I'm concerned old Al LaGuire is a full blooded Hawaiian.

Senator RIEGLE. We may get to see you in a hula skirt one of these days.

Mr. LAGUIRE. So I did want to mention that. And I have gratitude for those people out there and maybe a good idea that might—some of these things might work in other States.

I also, before I came in have to see my doctor regularly, of course; I said, "I want to be able to tell the Committee that I had asked—you know, that I was going to testify and say what have you observed particularly about prescription medicine?"

And my doctor, a real good guy, believe me, he said that it seems to him the people that need it the most are the ones that are least able to afford it.

Senator RIEGLE. That's right.

Mr. LAGUIRE. That's from the doctor's perspective and of course he sees it every day. He gets samples, of course, from pharmaceutical companies and has frequently supplied me with the samples.

Zantac is one that's a rather expensive thing I use a lot of. He saves me a lot of money. I'm sure he does that for other patients, too.

And my doctor recognizes that seniors are having a difficult time affording drugs. That's why I brought these figures in here. I summarized the figures, sent them into Chairman Dingell's, the committee—

Senator RIEGLE. We're going to make those prescription drug receipts you've got there part of the record, so I'd just note that for the stenographer.

Mr. LAGUIRE. Very good, sir. What I want to do is just mention—I won't go into details on it, because if there's anything I can't stand is to hear some old guy talking about his operation, especially if it's me.

But the figures that I've paid, out-of-pocket medical expenses, that I've summarized here, the surgical hose, for example, that I'm wearing now which are rather charming, cost \$35. You know, for a pair of stockings is quite a bit. I never paid more than 50 cents for stockings.

But down here is the total out-of-pocket of \$590.99. I just gave you my balance. And that ironically, as I was making this out, I remember when I—I'll just go back one more month while I was going through all this in April, darned if I didn't have one of my main teeth split right down the middle there, and I had to go and borrow \$615 to cap this tooth, which that was my adventure last month.

So 2 months in a row I've been ill a little bit.

Senator RIEGLE. Let's hope the next month is going to be a good month for you.

Mr. LAGUIRE. It's bound to be. It's bound to be. But as I say, in any case, if this information is useful to the cause, I'm so happy to help you.

And thank you for the chance for letting me state it.

FOLLOWING ARE THE TOTALS OF MR. LA GUIRE'S BILLS AND RECEIPTS FOR THE MONTH OF MAY 1994; PLUS AN EXPLANATION OF AN EMERGENCY DENTAL BILL:

(COPIES OF THE ACTUAL BILLS ARE HELD IN COMMITTEE FILES.)

OUT-OF-POCKET MED. EXP - MAY '94

CHECKS	LIST SINGLY	DOLLARS	CENTS
1	DOCTOR-ORDERED O.C. TUBES	3	69
2	DR. ORDERED SURGICAL HOSE	30	63
3	PRESCRIPTIONS		
8 ¹	ALLOPURINOL	8	27
8 ²	ZANTAC	48	83
8 ³	DECADRON	52	84
9 ¹	LIDERA-MIDE	20	70
9 ²	LOCALTROL	36	85
12 ¹	RESTORIL	17	32
7 ¹⁰	SHAW-MAG	9	99
11	FUROSEMIDE	4	89
16 ¹²	BUMEX	12	78
13	308 TOTAL MAY TO DATE	\$246	89
14	MAY "MEDICARE"	103	00
15	MAY PART 13 MEDICARE	41	10
16	MAY-TRAVEL-CHI	200	00
17	OUT-OF-POCKET TOTAL MAY	590	99
18	TOTAL INCOME \$1143.		
19	LESS (591)		
	TOTAL LEFT TO LIVE ON	\$552	00

ENTER TOTAL ON THE FRONT OF THIS TICKET

Orville A. La Guire

AN EQUALLY COSTLY DENTAL EMERGENCY HIT ME
LAST MONTH, WHEN ONE OF MY LOWER TEETH
CRACKED IN TWO, AS (AGING) TEETH SOMETIMES DO.
I HAD TO BORROW \$600.00 TO HAVE IT REPAIRED
(CROWNED CAP); WILL BE PAYING 13% INTEREST
AND NEED NEXT YEAR AND A HALF TO PAY
FOR IT...

Orville A. La Guire
(DR. MALLORY - APRIL 08, 1994) \$615.00

Senator RIEGLE. Thank you, Al. Let's give Al a hand. And let's thank Kate Carr, too, Congressman Bob Carr for their words, too.

Lisa, let me invite you to come on over now and sit here, too, if you would, please.

Al, thank you for these.

Mr. LAGUIRE. Thank you, Senator.

Senator RIEGLE. As Lisa is coming up, you'll recall I said earlier she's from Kalamazoo. She's the primary caregiver for her elderly and disabled mother Margaret who is 69 suffering from Parkinson's disease.

Lisa, come on right up here.

STATEMENT OF LISA MINOTT, KALAMAZOO, MI

Ms. MINOTT. Good morning. My name is Lisa Minott. I'm 32 years old. My parents raised six children and my father's nephew.

First, I'd like to thank you for inviting me to testify.

I'm a lifelong resident of Kalamazoo. I love my parents and my family very much. You should know that I've never participated in a public forum such as this before and certainly have never before shared any of the private details of caring for my parents.

I became the primary caregiver for my elderly disabled parents in 1984. My father, Donald Minott, died in 1990. My mother, Margaret, is now 69 years old.

In the 1950's my parents lived in a substandard tar papered home. They made many, many sacrifices so that they could own their own business, D & M Wrecking company.

In retrospect, I suspect that my parents' early struggle to keep their small business going paled considerably when compared to their almost two decade long fight with poor health.

As small business owners with a growing family, my parents were forced to make difficult choices regarding the very basics of everyday life. There were no discussions about pensions, retirement, or long-term care. In fact, there wasn't even life insurance.

For the future, they could only afford burial insurance and sporadic and very limited health insurance.

Like most Americans on the edge, we soon learned that you can be severely penalized for owning property, never mind that it wasn't generating income and nothing was growing on it. Owning property simply meant that we were not eligible for assistance to help pay for desperately needed health insurance.

Bad health, the business, and the stress of raising seven children began to take its toll on my parents early. My beautiful father was an old man at 50. In 1979 he had a minor stroke due to hypertension which altered his personality.

In the early 1980's he became completely disabled. He was not cognizant of the gravity of his illness, that he had lost most of the use of both of his kidneys. He was on dialysis for many, many years.

In 1990 he had a kidney transplant. After the transplant, he became completely bedridden. And after a few agonizing months, died.

My mother was diagnosed with Parkinson's disease in the mid-1970's. By the early 1980's, she was disabled. She was too young

for Social Security. Her disease wasn't on the list of diseases that Social Security identified as disabling.

She wasn't considered disabled even though she could no longer work because of the disease itself and side effects from medication. She couldn't drive or take herself to the bathroom. Her body was in constant movement from foot shuffling, drooling, and writhing.

She almost died during my senior year of high school because her out-of-town doctor took her off of all her medications without informing the family or her local physicians.

My parents' medication ran between \$500 and \$1,500 every month. Doctors' visits were excessive. Many doctors viewed them as card carrying members of the "Experiment of the Week Club."

The only criteria for joining the club was that you had to be a person of color, impoverished and not have a member of your family in constant attendance at doctors' visits with you.

I tried to get help through home care agencies. I found that many of the agencies were not affordable due to inflated prices. Agency personnel were often insensitive, ill-mannered, incompetent, and untrustworthy.

One particular incident comes to mind. An agency sent a supervisor and a new trainee to our house. I answered the door. "Hello, may I help you?" They identified themselves. I said, "One moment, please."

I stepped back from the door and heard the supervisor say to the trainee in disdain, "Oh, I had no idea they were black. You don't have to stay."

Those that did stay were inattentive and seemed to go out of their way to not help the person they were hired to help. They sometimes didn't change the linen or straighten up the area around the bed, but often did not or wouldn't help my parents in and out of the bed.

I complained to supervisors, then I changed agencies two or three times only to find that the normal attitude was one of indifference.

I tried to find services for my parents but ran into a lot of problems. I found that our society for years has considered women's lives to be expendable in many ways.

Society expects people to work for themselves—to work themselves to death for the elderly without any additional assistance. Stay at home, but don't get sick. Work hard, but don't get paid.

My family couldn't afford \$40,000 a year per person to put my parents in a home. Nursing homes are understaffed and let's not talk about the quality of care in them. Most people of color don't place their relatives in nursing homes. They keep them at home because it is cheaper and more humane.

That is why the Medicaid waiver must be implemented right away and is of such great importance for Kalamazoo and all of Michigan.

Please, people in agencies, stop playing games with peoples' lives because of private, personal, or hidden agendas. Health care has no place for it. This will happen to you.

My life has been hell, but I must say it has been an excellent learning experience. Becoming a caregiver at such an early stage in my life has been spiritually hard and financially devastating.

There's no reprieve, no respite. It is a 24-hour-a-day, 7-day-a-week, 52-weeks-a-year job. It is never ending.

The battle that I face all of the time is not to enjoy life but just to live and survive. Providing care is very hard. There's constant sleep deprivation. My mother needs help to go to the bathroom during the night. She often needs help in turning over in bed, a late night snack, or pain medication during the night.

I must prepare dozens of snacks and meals for my mother on a daily basis because of involuntary movements from Parkinson's disease that cause her to constantly move and burn calories at an extraordinarily fast rate. It is a struggle to keep her weight above 100 pounds.

I also must contend with scheduling medication, cleaning, making dozens of large and small decisions, filling out mounds of paperwork, transportation, hygiene, doctors and dentists visits and much, much more.

I am not working and my mother can't work, so there are legal troubles because there isn't enough money to pay bills. Creditors want you to settle your debts with them by whatever means necessary.

The house needs to be adapted to accommodate my mother's wheelchair. Doors need to be widened, floors need to be leveled, the bathtub should be refitted so she can maneuver around more.

My mother needs more food stamps. No one can live adequately on \$43 a month. The lack of respite care has affected every area of my life. For years, I've been uninsured. Those in the family who had insurance, all had clauses that did not allow for any family members to receive insurance under their policies.

I've sacrificed for long periods of time through extreme physical pain. I've known absolute despair and true isolation. I've been cold, hungry, and very disappointed about what my life has been like.

I worked hard so that my parents would not lose their home and everything else that they had fought for. I didn't want them to be cold, which they were at times. I wanted them to have enough to eat, which they did not at times.

I really don't have much of a life beyond caring for my mother. My sisters and I have made tough choices. There is a definite lack of social interaction. Due first to my father's needs and now to those of my mother, marriage and children are basically out of the question. We can't juggle babies and disabled parents at the same time.

My siblings have passed up good jobs in order to remain within driving distance of my mother in Kalamazoo. I know that my sisters have struggled financially for many years to try and keep me and my parents afloat and in their home.

I want to be pleasant to my mother and treat her with total kindness and respect every day. This is very difficult to do when I'm always so very tired, stressed, and overwhelmed by the demands that I face each and every day.

Respite care would allow much needed time off, a chance to break the stress and monotony for the receiver and the same for the caregiver.

People should not be put in the position of leaving unidentified loved ones at emergency rooms or abusing them because the frus-

tration is so high and the fact that the resources are not there to alleviate the situation.

My wish is that my mother's life, which may go on for many, many years may be viable. Please notice I didn't wish for a happy or enjoyable life, but life, some small pleasures here and there. She needs some variety.

If she was able to get some additional care, she'd be able to get her hair washed more often. Someone could drive her to K-Mart, push her in her wheelchair through the mall or go to the community center to eat with others or visit a friend. If she had physical therapy, perhaps she wouldn't experience so much pain and discomfort.

My parents spent their lives as hardworking and productive citizens, paying into the system. Although my father didn't survive, I do want Margaret Minott's life to be better.

She is a loved, loving and intelligent woman. I want my mother's children and grandchildren to know her as a person. She has played and will continue to play an all-important role of mother, friend, and advisor in our family. I did my best. Life is hard enough without people being harder.

Senator RIEGLE. You know, these stories go on all over this country, every hour of the day. And there's so many invisible people who are doing such heroic things to help loved ones and they don't have what they need to work with. They're sacrificing their own lives, their own opportunities to try to meet these basic needs. And we need a different system in the country. You know, it's not right and it's not good for the country to go through that kind of level of difficulty and deprivation and the wasting of lives, when we can work out a system to meet these situations. And it can happen to any one of us.

Lisa has described so powerfully her story. But you know, her story tomorrow or next week might be our story. You know, we all can be walking in the other person's shoes, without any warning.

And so I think it's so important for us to understand the human side of this. We see all these television ads right now being paid for by certain special interests who've got money to spend to try to take and push the debate this way or that way.

Ms. MINOTT. And they've never been hungry or cold.

Senator RIEGLE. I think that's right, nor is their interest focused on the people who are hungry and cold.

Ms. MINOTT. That's right.

Senator RIEGLE. That's why I think as a people we have to decide what we think is right and what we think is fair and what we think works. The insurance principal does work.

If we all can, based on our ability to pay, and with some fair sharing, if we can all put something into the pot for health care, then we can all take out what we need when these special problems arise.

We know it works because it's working in all the other countries. If it can work in the other countries, why can't it work here.

Well, it can work here. But I think it's also fair to say there are an awful lot of people who make an awful lot of money the way the system is today.

Ms. MINOTT. Off of your misery?

Senator RIEGLE. Off of the misery and the suffering and the absence of help to a lot of people. And so a lot of the people who defend the status quo, are helped by the status quo but that doesn't solve these other problems that we've just heard described here now.

But we've got other witnesses to hear. I think we should really give Lisa a special acknowledgement for coming today, sharing the story which is very painful to tell, painful to listen to but it's real and it's happening and it's happening to millions of other people.

And the fact that she's come and told us today is a great service to this country. Thank you, Lisa.

Ms. MINOTT. Thank you.

Senator RIEGLE. Let me, as our next witnesses are being seated here, I want to acknowledge Diane Braunstien, who is here, who's the director of the Michigan Office of Services to the Aging who was downstairs in the earlier session and she has been here.

And Diane, why don't you just stand and be recognized.

Ms. BRAUNSTIEN. Thank you.

Senator RIEGLE. We appreciate your work and we appreciate that you're here, too, to hear these stories because it's so important that this information be shared and that we take it all in together.

Let me just take a minute and say that Debbie and Rick Arnold are from Pontiac. They're here to talk about their son, Christopher, who is suffering from an immune deficiency disorder and the problems they've been facing.

I try every week in the Congress and the Senate to go on the Senate floor and tell an individual story of a family or person in Michigan who's struggling with a very serious health care problem to try to help the country understand and the Senate understand what's really going on in this area.

And so I have done that with their particular problem which they're going to outline here today. But I'd like them now to go ahead and tell their story.

STATEMENT OF DEBBIE ARNOLD AND RICK ARNOLD, PONTIAC, MI

Ms. ARNOLD. First, I'd like to thank Senator Riegle and all of you for being here.

As Lisa and I were talking, I also grew up with a family of severe illness. My mother suffers from manic depression and 4 years ago my father had brain surgery, a very viable working part of America, had a brain aneurism, survived an unbelievable surgery and was one of the early retirees you're talking about. And as she said, it's very hard to juggle the entire act.

Well, my husband and I have been married for nearly 20 years and we've raised two children that have had very chronic illnesses. Our son now is 6 years old, he has a primary immune deficiency, which means his immune system does not work correctly, therefore he's not able to fight off infections.

So when you speak of steroids, my son has known them since day one. Now I understand why his joints hurt. It's probably the steroids. I never put two and two together until just now.

I, too, like Lisa, had never spoken to anyone. You carry this heavy burden in your heart because people don't understand. My

husband and I were fortunate enough to start on the Immune Deficiency Foundation for Michigan last April.

I want to recognize them because I'm honored that a group of ours has come from all over the State. Also we have someone from the State of Indiana who came. She makes \$34 too much to receive State assistance so they have no insurance for their child. She comes to the University of Michigan to receive treatment and it's coming out of their pocket. We have no idea how they're going to pay for it.

But basically to start with, I'd like to share a poem that a special health care services coordinator gave to one of our moms yesterday. It says, "To All Special Moms Blessed With Special Kids."

"Did you ever wonder how mothers of handicapped children are chosen? Somehow I visualize God hovering over the Earth. As he observes, he instructs angels to make notes. 'Armstrong, Beth; son; patron saint, Matthew; Forrest, Marjorie; daughter; patron saint; Cecelia.'

"Finally he passes a name to an angel and smiles, 'Give her a handicapped child.' The angel is curious. 'Why this one, God? She's so happy.' 'Exactly,' smiled God. 'Could I ever give a handicapped child a mother who does not know laughter?'

"'But has she patience?' asks the angel. 'I don't want her to have too much patience or she will drown in a sea of self-pity and despair. Once the shock and resentment wears off, she'll handle it.'

"'I watched her today. She had that feeling of self and independence that is so rare and so necessary in a mother. You see, the child I'm going to give her has his own world. She has to make it live in her world and that's not going to be easy.'

"'But, Lord, I don't think she even believes in you.' God smiles, 'No matter. I can fix this. This one is perfect. She has just enough selfishness.' The angel gasped, 'Selfishness?'

"God nods. 'If she can't separate herself from the child occasionally, she'll never survive. Yes, there is a woman who I will bless with a child less than perfect. She doesn't realize it yet but she is to be envied. She will never take for granted a spoken word. She will never consider a step ordinary. When her child says momma for the first time, she will be present at a miracle and know it!'

"'When she describes a tree or a sunset to her blind child, she will see it as few people ever see my creations. I will permit her to see clearly the things I see—ignorance, cruelty, prejudice—and allow her to rise above them all. She will never be alone. I will be at her side every minute of every day.'

"'And what about her patron saint?' asks the angel. God smiles. 'A mirror will suffice.'"

Our son has seen 17 doctors in his short 6-year life. Hospitalizations for surgery, infusions, CAT scans, ultra sounds exceed 40 to 50 visits between six different hospitals, including university settings.

Ten surgeries have been performed, numerous blood tests, countless IV infusions. And now we have the opportunity to go to the National Institutes of Health in Maryland as part of a research project for Pheresis study and hopefully the beginning of gene identification and the future of treatment.

I didn't bring figures because our figures are astronomical. Pam, on the way up, her son was just hospitalized at the University of Michigan for one pneumonia stay of less than a week. It was between \$25,000 to \$30,000. We're going to hit lifetime maxes before our kids probably even see 10 years old.

The most important thing to me is the freedom to be able to choose my doctor. After seeing 17, I found one who cares, who has compassion. Right now he's in India at the Mecca praying for his children. And he's not talking about his children. He's talking about his patients.

To me, it is imperative that we have choice. That our primary physician, in our instance, can be an immunologist or whatever specialist you need for that diagnosis. They have to be the primary doctor to care and coordinate the treatment.

Typically, when you look at our son he doesn't look ill. He's a happy bouncing boy. You would never know what he has endured. He never complains.

But you have to be very astute to understand those symptoms. If the fever starts to go up, you better go in a hurry because guaranteed in less than an hour, it'll probably be 105 and you'll be in an acute situation.

He's missed approximately 40 to 50 percent of his school day. That opens a whole other nightmare, if you could imagine, because then you have to get homebound teaching. You have to get all these other coordinated efforts that people look at and go, "He's not handicapped. He doesn't have a wheelchair."

Recently we experienced a worldwide recall of the very drug that sustains his life. It is a blood byproduct. It's called gamma globulin. Unfortunately, I don't know all the circumstances, but hepatitis C has been reported. It has been traced in several cases throughout the world.

So not only do we have a life-threatening disease, we now have one of the very viruses—it's not AIDS, though. I thank God, it's not AIDS, but it's very, very concerning.

When you talk to specialists, you ask, "What research is there?" "Well, we don't know because an immune deficient person acts entirely different than anyone else, so therefore all these studies we have on hepatitis C mean nothing for your child. We're going to have to observe him. We're going to have to do blood tests periodically and look for the warning signs."

I have to thank the FDA. After 2 years, they have finally given us verbal approval. Hopefully it will be on the shelf within the next 2 weeks.

However, this brought another concern to me because the very hospital that treats my son refused to treat him because they considered during the FDA's approval, as far as compassionate care, they considered it still an experimental drug. So therefore we were not able to be treated in the hospital with the infusion.

I've had better luck with home care companies. I finally found a wonderful one. I will fight for them for the rest of my life. They took it upon themselves the liability of treating my son at home because they knew he needed his infusion to save a further infection.

Therefore, they took the risk of taking him. If he had a reaction, they could be in very big trouble but they have been our Godsend.

The Epi Pen Injection, "911" would receive a call, then the emergency room at our local hospital.

We also have the fact of the COBRA nightmare. My husband is an insurance agent and you might want to throw darts at him before we leave this stage, but his company's way of fixing the health care reform was to actually fire all their agents and make them independents.

So therefore, not only did we lose what little health care coverage we had. We're now on COBRA. We do not know if he will be able to be insured within 18 months. We also lost all our benefits. We would have already used up our retirement anyway, but now we have nothing to go on in that regards.

Last November just before Senator Riegle profiled our family, probably our biggest financial crisis was our home was in foreclosure three times. We were a veteran, so we thought we were safe.

When they came out to do the second appraisal they said, "Don't worry, VA will not leave you stranded." Well, folks, unfortunately we were on the road to no recovery until we found Standard Federal.

We had a loan officer who sat down. She listened. She jumped through hoops and so did her staff and within 24 hours of our house going on the sheriff auction, we were remortgaged.

Our payment dropped enough that we could afford the house payment and we thought finally, we have two cars that are 150,000 plus miles, God granted, they still got us where we needed to go. But when Christopher had surgery in January, the heater went out in the car and we had to drive to Detroit and back.

So we went on New Year's Eve and explained our saga to the car dealership. And they said, "We're going to have a car for you so you can take it." They gave it to us at invoice. People do listen and they do care. They do what they can.

But now I don't know if we're going to be able to pay that car payment because now we have the COBRA payment and we have all those other things so we're back in the same strap we were last November.

But my concerns are, because we are in a very new field, our particular illness, is on the cutting edge for research and the very essence of science.

David, the little boy in the bubble, I'm sure you all remember him. He suffered from severe combined immune deficiency. That is now cured by gene therapy. Gene therapy is the only research hope that I have for my son.

For many diseases, that is where they're looking for cystic fibrosis. It's very costly. I know there are people without insurance and I know I've been very close many times. But we have to also keep the vision of research as part of that program.

And the pre-existing clause has to be abolished. That is totally inhumane. Why in America when we speak of rights and prejudices of color or race or religion, are we allowed to discriminate because someone is born with an illness that they have no control, because that gene is there and has made them different.

I don't want to use up all my time because my husband had a few words. He wasn't going to speak, but I thank you for listening

and I will pray for all of you because I know everyone in this room has the same concerns I do or they wouldn't be here.

Thank you.

Mr. ARNOLD. I'm going to switch from the tear jerker part of the situation to a little bit of a reality check. And just for those of you that are in this room, if you'll raise your hands, how many people in here have automobile insurance?

Do you know that if you get in an automobile accident, any medical bills that are not covered by health insurance in this State will be covered under your auto policy for as long as you live? How many people knew that?

Then I propose if we can put that in our auto insurance law in the State of Michigan, why can't we do something in the health insurance area for things other than auto or auto-related accidents. Okay.

One thing I want to stay away from in health care reform is pointing fingers at who's to blame. Everybody involved in the health care system shares the responsibility and some blame for abuses which have created some of the problems.

Part of the problem we have in the health insurance industry today is research and diagnosis and life expectancies have far exceeded and are far out in front of those agencies capable of handling the situation.

I don't remember exactly what year it was Senator Riegle was talking about, but how many people here were here to see when Social Security was enacted? Tremendous amount of people.

How many people were alive to see when they found a cure for TB? Okay. How many people here went through the recessions in the 1920's? Major changes. Major changes.

What we've come to the point now is we have enough problems and enough uproar that now we're able to say, "The system no longer does what it was originally designed to do. It's been outdated. We have to revamp it."

One of the things that my concerns addresses is when you're dealing with health insurance companies, we have been told no so many times that we have become conditioned to accept that whenever the responses come, whenever you put a claim in, you get somebody says, "No, that's not covered."

Well, what you have to understand is you've got a lot of people in the claims departments of insurance companies that are handling health insurance that don't know any more about it than you do in this room. What they have is a computer that has coverage codes that says it is either a yes or no situation.

If you've got people in doctors' offices that are not putting the proper codes on the claims forms—and I don't know how many of you people have experienced it, but we've seen it time and again—you get a denial. And like most people, you accept that, so what happens, you pay for it out of your pocket. Okay.

Don't accept the first no. Go up above somebody's head. Case managers. How many people know about case managers in health insurance? Well, I'm seeing three hands out of this whole room.

Do you know that you can demand a case manager that will study your case individually and make an individual judgment on

your particular circumstances? But you have to ask for it. They will not make that available to you unless you bring it up.

One thing I want to see with the health insurance companies is no longer a black and white code. Research, diseases, conditions, circumstances should all be treated on an individual basis with guidelines as criteria.

There's not anybody in this room, I'd be willing to bet, that can say, "I have exactly the same circumstances with my health care as far as my health itself is concerned as anybody else in the room."

But when you get a claim form sent to the health insurance company, you are treated exactly the same as anybody else with that diagnosis.

That's one of the things that immune deficient patients have run into. And I'm going to bring this in a little bit for the fact that we've been talking about my son.

The problem is there is a tremendous amount of adult onset patients who get this same disease at age 30 or 40 or 50 or even more, where all of a sudden, the normal common cold, the flu, pneumonia, whatever it is, every time you come in contact with it, it is now a life-threatening situation because of the fact that your body isn't functioning properly anymore. Now, think about that.

Health care reform has got to have the ability and freedom of choice which was put into our Constitution in the United States that has given us freedoms to do just about anything that we want to do.

But on the other hand, we're being told that if you're in a PPO and your doctor does not want to send you to another physician or a specialist, you don't get to go and have it covered.

My wife said we've been through 17 doctors and you want to know why? Because like in any profession, there are good people and there are not so good people or—I know, I heard her.

The competency rule, if you will, you have to judge the individual you're dealing with. You have to have trust in them and you have to feel that they know what they're doing to take care of it.

And the last things I'm going to say and I heard this on cable. We got cable the day that Senator Riegle profiled our son on the Senate floor.

And I'm not going to mention his name but there is a well-known Representative in the House that made the statement, "There is no health care crisis in this country." If I could have reached through that television, I'd have grabbed him by the throat.

Just like Lisa said, they don't know what it's like. They've never seen their kids or their loved ones in a hospital bed. They've never had the denial and the self-sacrifice.

And I just want to tell you people, now is the time to stand up and be counted, because whatever we get is what we're going to be living with for a long time.

Thank you.

[The prepared statement of Mrs. and Mr. Arnold follows:]

Statement of

Debbie Arnold
Pontiac, Michigan

Health Care Reform -- Implications for Seniors



IMMUNE DEFICIENCY FOUNDATION

MICHIGAN CHAPTER

The National Organization Devoted To Research And Education For The Primary Immune Deficiency Diseases.

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NATIONAL HEADQUARTERS
COURTHOUSE SQUARE
3565 ELLICOTT MILLS DRIVE
UNIT 102
ELLICOTT CITY, MD 21043

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Diane W. Wais, M.D.
USF Medical Center
San Francisco, CA

Tony Webb
Executive Director

May 6, 1994

TO: Elizabeth Gertz / Senator Donald Riegle Jr.

FROM: Debbie Arnold-Michigan IDF

RE: Testimony-Healthcare Reform May 18, 1994

TESTIMONY--Will We Ever Smile Again?

YES!! With answer to prayer it is my sincere "Hope" that these hearings and testimonies will bring about change. The "American Dream" for many of us has taken an alternative route....It is of great concern to me how many still do not realize the impact this crisis of health care in this country has caused on our total picture....

I was talking to Rep from a pharmaceutical yesterday, I mentioned to her, "If this crisis was the oil spill in Alaska and the natural habitat was endangered, all forces would be out to clean up and try to restore order as soon as possible....If my child was the whale that had beached himself on the ocean shore people would come from all over to help and return him to his normal way of life"...That's all we were asking for --to be given the chance! You see my son has been in the hospital so many times they know his name and diagnosis in admitting without even having to look it up.

We have seen 17 doctors in his short 6 years of life, Hospitalizations for surgery, infusion stays catscans ect. exceeds 40-50 visits between 6 hospitals. Ten surgeries have been performed numerous blood test and countless I.V. infusions...and now we have the opportunity to go to the National Institute of Health in Bethesda, Maryland to be a part of the Research Project for Pheresis study and hopefully the beginning of "Gene" identification and future treatment of his disease.

The freedoms to be able to choose my doctor, care facility or homecare company is imperative....Choices can't be made for my son without consultation of his Immunologist, who even though he is the "Specialist" he is the "PRIMARY CARE PHYSICIAN". The needs of choice of product for treatment and risk involved if the wrong one is used can be "Life Threatening"

Our son became ill very early in his life, his first surgery occurred before he was a year old. Now at age 6, he has gone through numerous hospitalizations constant antibiotic therapy, IVIG therapy (intravenous) infusions every 2-3 weeks and periodic breathing treatments which have become his way of life.

Typically, when you look at him, most often he appears to a normal 6 year old child which is indicative of this disease until his IV treatment runs down and even his treatment is no guarantee that he won't become ill. Approximately 50% absent from school days gives a better idea of what he goes through.

Recently, we experienced a world-wide recall of the specialized product used in his IV Therapy which put him in grave danger because that product is essential to his maintaining his health. Without it, death could be the result.

We now have a new product available under compassionate care that has just been recently approved by the FDA but even our normal hospital refused to administer it because it was not completely approved by the FDA but only for compassionate care treatment. (Imagine needing a life giving drug that was available but not approved for use and watching your child or loved one suffer and possibly die because of it. I won't describe the emotional, mental and physical stress that this puts on the patient and family members as well, while they're trying to cope with the everyday normal stress just from the disease existing.)

Ongoing research is imperative to the cure and treatment for people to assure quality of life. Gene therapy has been used and been successful in some treatment along with bone marrow transplants. These procedures are available because money was there to do the job. It is imperative that these types of breakthroughs continue for not only people with our son's disease but in any chronic illness.

Homecare has been a Godsend for a number of reasons. Treatment is given in a more familiar surrounding making it less stressful on our son. It is far quicker than in the hospital and a lot less expensive than the hospital. The biggest benefit is the fact that he's not in a building full of sick people. (Last time he was in the hospital, they put him in a room with a boy who had chicken pox so bad that it had gone into his bone marrow which is really stupid.)

We currently have an Immunologist as our primary care physician who coordinates treatment with the pediatrician and the ENT doctor if necessary. It took us a couple of years to finally find the people needed to give our son the care he needed. We went through many so called primary care physicians who did not have the qualifications and experience that were needed to give our son proper care and quality of life.

In our situation and the case of most if not all chronically ill patients; if we didn't have the ability to choose our physicians and the way we receive treatment, we would have a much higher mortality rate than we have simply because our options were limited. It is imperative that the choice of physician and treatment be left to those who are most affected by it; the patient.

Health insurance has been another nightmare. Between deductibles and co-pays and claims people who don't understand and refuse or deny claims that we have had to go back 2 or 3 or 4 times and finally get things paid, you get an idea of what we go through. We even got to a "case manager" and showed them in dollars and cents why it would be their advantage to pay for home health care in our sons situation instead of making him go to the hospital for his treatments. When that happened, we got our home treatments covered and paid for by the health insurance carrier. (Just good Business)

Now we face a new situation. My (father's) employer just eliminated our health care program and I am now under the COBRA program for the next 18 months. I now pay higher premiums and even though I have been assured that I will be able to convert to a similar plan without any evidence of insurability, who really knows what will be available 18 months from now. (Imagine our dilemma. Bottom line: WE HAVE NO CHOICE) Our situation is the dictator here.

The economic impact of this disease is unbelievable. We make over \$40,000 a year; bought our first new care in 10 years; live in a modest \$60,000 home that we've been in for 10 years and yet because of the medical bills and lost time from work to care for our son; we faced foreclosure on our home twice in 1993 and after many attempts to find a financial institution that cared and understood the uniqueness of our situation, we closed on a new mortgage in November 1993 just 1 day before a Sheriff's auction would have sold our home and created another "homeless" family because of the impact this disease can have on the financial well being of a modest American family.

For those Senators and Representatives in Congress who have stated "There is no health care crisis" WALK A MILE IN OUR SHOES. They will never know unless they have lived it.

Through the support of our Church and our love of our son Christopher and the love and support of his sister Delena, we have survived and there have been times when we really didn't know what tomorrow would bring but we are still working hard to keep him healthy and happy.

The very product that saves our son's life was voluntarily recalled off the market by the manufacturer. Now it is our understanding that they had gone to the FDA for approval of processing purification upgrades in August of 1992, and approval has still not been fully granted. Now, 8 months later they're worst "FEAR" is a reality. Worldwide reports and confirmed cases of Hepatitis G due to possibly contaminated Blood & or Blood-By products. Screening tests are not absolute virus are changing every day--no guarantees....Our child is at risk and where does the responsibility lie.....

This in itself is very serious for the normal person but for the Immune Deficient person, it's unbelievable! The only test to confirm exposure is the RNA/DNA test which is a very expensive gene identification process which is newly developed and not even available at all facilities as of yet. If confirmed; the only treatment is Interferon and/or liver transplant. Both procedures are questionable for Immune Deficient patients, because no studies are available on these types of patients...as with many of the surgical procedures, data in many cases of study are less than 5 years and that puts us on the cutting edge of research. Gene Therapy has been done for SCIDS children, making the plight of "David, Our little Boy in the Bubble" a part of history with a hopeful ending...If research continues. Bone Marrow transplants and Gammaglobulin Therapy are a successful part of treatment and cost effective measure for the Insurance Companies if they do cost comparisons of repeated hospitalizations for infection vs. therapeutic treatment. 1 in 500 suffer with nearly 70 forms of primary immune deficient diseases, there should be a chance for everyone of them.

Today he cannot receive his infusion in the hospital, however, our homecare company made concessions knowing his treatment was a necessity, even though, the manufacturer suggested two treatment in the hospital before giving the treatment at home. It is my opinion that the legal department at the hospital has advised them to abstain from complying with the compassionate care, making it nearly impossible for my doctor to complete the paperwork for an internal review boards approval at the hospital.

- 1) there's no profit on this product for the hospital because the manufacture has given it free of charge under "compassionate care" and the only money the hospital receives is for the service they provide. There is also no guarantee the insurance company will pay because this may be called "experimental"
- 2) they're also concerned with their "liability" using a drug that has been approved of use by the FDA for "compassionate care only"

New product availability has caused a 30% shortage on the market, no mandates have been made or guidelines in place for prioritizing release of product...In many it's a matter of life and death we cannot make concessions...Lot #'s must be recorded reporting of "Reactions" must be done and better communication between corporations are a must! Universal Claim Forms would make processing much easier and someone picking up a phone to clarify a missing number or letter, instead of sending back for denial without reason other than the attitude "It's not my problem" would make all our lives easier!!!

We thank God everyday for each other and for the support of other people in situations like ours. We started the Michigan Chapter of the Immune Deficiency Foundation in April 1993 and have educated not only other families and patients but many medical professionals as well as to the complexity and severity of Immune Deficient Diseases including the heads of many Immunology Depts in many of the areas' major hospitals and medical centers.

In Summary: Ours is a typical scenario where Immune Deficient Diseases are concerned as well as many other forms of Chronic Illness. We need affordable health care coverage; freedom of choice to get to those professionals that are capable of helping us without limiting us to those who may not be able to; research to seek out those cures that will not only improve our quality of life but make us more productive members of society because of it; educate medical professionals and society that Primary Immune Deficiencies are not AIDS but they often result in pre-mature death.

Thank you for the opportunity to present this to you and also attached is an article from the Oakland Press newspaper on April 6th, 1993 with Christopher's story.

Let this be a message to those who have the power to affect all our lives. Listen well and take heed.
THIS IS A TRUE STORY. THESE ARE REAL PEOPLE.

In closing, the words from Matthew 5:1-12 "Blessed are the poor in spirit, for theirs is the kingdom of heaven. Blessed are those who mourn, for they will be comforted. Blessed are the merciful, for they will be shown mercy. Blessed are the Peacemakers, for they will be called sons of God. Blessed are those who are persecuted because of righteousness, for theirs is the kingdom of Heaven.

"Blessed are you when people insult you, persecute you and falsely say all kinds of evil against you because of me. Rejoice and be glad, because great is your reward in heaven, for in the same way they persecuted the prophets who were before you".

Thank-you with sincere appreciation, . . .
Gods Blessing,

from my husband Rick and "myself"
and our wonderful children, Denena and Christopher

submitted by:

Deborah L. Arnold
153 Cherokee
Pontiac, MI 48341
(810)332-3591
SS#382-72-7292

Senator RIEGLE. Thank you. Good job. We're going to go in just a moment to our second panel here.

And I want to just say to all of you that are in the audience and particularly to those that have just given these statements, how important this is as an act of citizenship and public service that each of these people have come here today and have come up here and have prepared these statements and sort of opened up their lives to share what's going on, as painful as that is to do because it helps us see what's happening to so many others.

These are wonderful acts of public service and citizenship that you've each performed today. And there are not words adequate to express the admiration and feeling that all of us in this room have for each of you as you struggle with these problems.

You know, we need prayers in addition to all the doctoring and the good medicines and the other things we can get our hands on and a good health care system which is urgently needed.

But I think it's fair to say that you've together touched every life in here. And I think we'll all be different and better and wiser as a result of what you've shared with us today.

So when you go back to these difficult problems, you're not going back by yourselves, you're taking us with you and you're going to be—we're going to be there thinking about you and trying to get things done that will help you, each of you. You can count on that.

Ms. MINOTT. Thank you.

Mr. LA GUIRE. Thank you, sir.

Senator RIEGLE. Let me now introduce our final three panelists here that are—we're running a little long, as these kinds of situations sometimes do because it's important to take the time to hear these stories.

What we're going to do at the end of this hearing, because we're going to be very pressed for time and I've got a health care meeting in fact late today in Washington that I must try to get back to so the bad guys don't get bad things done while I'm not there. I want to be here, but I want to be there, too, because I want to be there to make sure these things are taken care of as best we can take care of them.

Many of you are going to have suggestions or questions or points of view that you want to express. And I want to make sure that you write down on a piece of paper any question you have or observation you want to make or story you want to tell and I will answer each of those that requires—if it's a question that requires an answer, as best I can. And I'll send it to you in the mail because we're not going to be able to do them all today here one by one.

I pledge to you that if you give me a piece of paper with questions or observations on it that ask for comment, you'll hear back from me. And so I want those given to us so we can do that.

I also will take any statement that any of you want to prepare, like you just heard delivered by these other folks, if any of you have a statement that you want to make and you give it to me, I will put it in this Committee record and we'll make it a part of the official record of the Senate Aging Committee, which in turn is going to be made a part of the formal Conference on Aging by the White House which is coming up.

So this is an opportunity for you to do that and have that kind of an impact without necessarily coming up here and speaking in a microphone today. So that's an opportunity that's available to you.

You don't have to just write it here in the room. If you want to write something and get it to me in the next week, I'll make sure that it becomes a part of this Committee record.

And be sure to put your address on what you write. I've got one up here right now that doesn't have an address on. I'm going to need to get an address on this so that I've got a way to get back with you. So be sure to put a mailing address and print it so I can read it clearly.

If I may, let me now introduce our final three panelists. Joyce Gallant is from Detroit. She is chair of the Michigan AARP Health and Long-Term Care action team in Detroit. It's a very important position.

I'm going to have her come right up here and sit beside me and pull this mike over. She's here to discuss the various aspects of health care reform that affect seniors that come off her leadership work in AARP.

She'll be followed by Mr. Robert Dolsen from St. Joseph, Michigan who is the executive director of the Region IV Area Agency on Aging and has been a leader in the aging network now for more than 20 years.

And he's here to talk about what his region is doing with respect to successful Medicaid home health care efforts and the long-term care needs that he sees and wants to comment upon.

And then finally Dr. James O'Brien who is here from Lansing, Michigan, is currently a professor and associate chair of the Department of Family Practice at Michigan State University.

He's the medical director of geriatrics at St. Lawrence Hospital and chair of the Committee on Aging at the Michigan State Medical Society. So he is an enormously important resource to us on the professional side here to discuss his perspective on the current health care delivery system.

So Joyce, we're pleased to have you and we'll take your statement now.

STATEMENT OF JOYCE GALLANT, CHAIR, MICHIGAN AMERICAN ASSOCIATION OF RETIRED PERSONS, HEALTH AND LONG-TERM CARE ACTION TEAM, DETROIT, MI

Ms. GALLANT. And I certainly want to thank you, Senator Riegle, for this opportunity. On behalf of AARP members, let me thank you for your serious attention to what is the most important public policy and family concern for older Americans today, health care reform.

And certainly after hearing each of the stories presented, it just reiterates to me the grave need for health care reform in this country.

AARP firmly believes that reform must guarantee every American the following: Health care coverage, not merely access. We have access now, but we must have universal coverage, a comprehensive benefit package that includes prescription drugs and long-term care for Americans of all ages.

We need a systemwide cost containment that yields affordable care coverage and strengthens the Medicare program. These objectives are essential for a good health policy and for a good economic policy.

We need universal coverage, as mentioned before. One of the clearest messages in this debate is the public's call for universal coverage—not merely as a goal, but on a timetable that is specified by law that Americans recognize. Unless everyone is covered and shares in the financial responsibility, cost-shifting and inefficiency in the system will continue to occur.

We've heard a lot from business groups that want to reject responsibility for their share of costs, even while the rest of us help to subsidize these costs for their workers and dependents. An employer mandate would help to level the currently uneven playing field and permit us to establish health insurance that is fair and affordable for all Americans.

Certainly we need long-term care. While over 37 million Americans have no insurance to cover hospital and doctor costs, over 200 million Americans have no insurance for long-term care costs.

There have been incidents cited today, so I won't belabor that further. But certainly we feel that we must include long-term care in a reform package.

All family members are vulnerable—children who are born with birth defects or various illnesses as you've heard described today, parents who are injured by accidents and grandparents. No generation is spared. We need long-term care to cover all of these situations.

Yet few can afford to pay the high cost of such care. To American families, a \$20,000 bill for home care services is no different from a \$20,000 hospital bill. It's still \$20,000 they don't have.

We need to have prescription drugs. About 70 million Americans currently, as we know well, lack prescription drug coverage. Those who cannot afford to pay for prescription drugs are often denied access to essential life-saving drug therapies.

Or if they do take them, and this is indeed a tragedy, often they have to reduce the prescribed dosage and that, of course, defeats the medication's purpose.

This can compromise their health status and make them more likely to need more expensive acute care. The problem is most severe. And we must, we simply must, have a package that includes prescription drugs.

AARP firmly believes that any viable health care reform proposal must include a prescription drug benefit for all Americans.

Cost Containment. AARP believes that given the rising costs throughout the health care system, it is absolutely critical to make health care affordable for families and the government.

And we have mentioned here, this is America. We are the people. We must have provisions so that we can be taken care of. Any of us can face a crisis on any given day and our life would be changed drastically thereafter.

President Clinton and cosponsors of the Health Security Act have shown their willingness to establish tough systemwide cost containment. Now we need to go the next step, enacting health care re-

form legislation that addresses the public's overriding concern about the cost of care.

While efforts to promote competition can play a useful role in reforming the health care system, there is little evidence to suggest that the competition by itself will solve our problems.

The approach relied on in both Senator Chafee's and Cooper-Breaux bills will adequately contain health care costs. There's little evidence to indicate that just to have competition for competition sake will solve the problem.

Medicare. While the Medicare program is popular and successful, it has major gaps in coverage that, over the years, have eroded its promise of security for older Americans.

On the average Medicare now pays for only about half of Medicare beneficiaries' total care cost. Medicare can and should be expected to be a part of any cost-cutting effort.

AARP will oppose any further cuts to Medicare, because it will only lead to further cost shifting and growing access problems for Medicare beneficiaries.

Further, as Medicare savings result from health care reform, it will be essential to redirect those savings toward filling the major gaps in Medicare—chiefly, coverage for long-term care and prescription drugs.

In conclusion, Senator Riegle, AARP is committed to working with Congress to ensure that Americans of all ages have affordable health security, and that older Americans can rely on a strengthened Medicare program for years to come.

Let's do it now. Let's get it right. I appreciate this opportunity.

Senator RIEGLE. Mr. Robert Dolsen is coming up, introduced earlier from St. Joseph, Michigan. He is Executive Director of the Region IV Area Agency on Aging and a leader in this area and we'd be pleased to have your statement now.

**STATEMENT OF ROBERT DOLSEN, EXECUTIVE DIRECTOR,
AREA AGENCY ON AGING REGION IV, ST. JOSEPH, MI**

Mr. DOLSEN. Thank you, Senator. I certainly want to thank the Senator for giving us the opportunity to share with you, all of you, what we have learned in our experience with a home-based long term care system.

I'd like to address three issues:

(1) Are great numbers of older persons becoming eligible for Medicaid by using trusts to bury their substantial assets for their children as we often see in the media exposes?

(2) Can home-based services have an influence on nursing home occupancy and the use of medical services?

(3) Can the nation afford a universal, community-based long term home care system?

These aren't new issues. We considered them when we initiated our care management program 11 years ago and as it has evolved into the Medicaid waiver program.

Well, who are the older applicants in the Medicaid waiver program? They are not wealthy people using clever legal techniques to squirrel away their fortunes.

These people are from the disintegrating middle class, persons with incomes under \$13,000 a year with very modest nest eggs ac-

cumulated over lifetimes, usually not exceeding \$20,000, which they dutifully spend down before they become eligible for help. And they generally have families who do not exploit them but indeed sacrifice deeply for them.

The average age of our elderly clients is well over 80 years old, although over 20 percent of our clients are under 65. They are more than often—more often than not women, usually living alone.

They come to us for help usually in a health crisis, suffering a disability or an illness they have not anticipated.

Their shock is compounded when they learn that they must be impoverished to receive help. And why are they surprised? These traumatized older persons erroneously assumed that when the cost of private insurance to secure one's hard earned savings outstrip an individual's ability to purchase it, then policymakers will establish public insurance programs to serve that purpose. It's a principle on which Medicare was based.

Instead, the nation has said to them, "We don't want you to get away with spending any of your savings on a divorced daughter or a son hit by a corporate downsizing or a grandchild trying to get through school.

"Even though you've worked hard and contributed all your life and saved a bit, as you were encouraged to do, we want you to burn up that little bit you've put aside before we'll help you. And oh, yes, one more thing, after you're gone, we're going to have your home sold so we can get our money back."

Those with whom we work are spared the third shock—that without the waiver in place, they would have had to go to a nursing home to receive any help. Without exception, they are most grateful for the opportunity to stay in their own homes.

And they are most grateful to find teams of expertly trained registered nurses and social workers to explain their options and to carry out their choices in a compassionate and consistently professional way.

But is this home-based waiver efficient, the preferences of disabled persons aside?

We realized at the outset that if we were to have a significant bearing on nursing home occupancy or the use of medical facilities, we would have to confine our efforts to those who truly needed the services and we target tightly.

All our clients are certified to be medically appropriate for nursing home placement by the Michigan Department of Public Health; and the impact of serving this at-risk group has been profound. We have laid to rest the notion that if you build a nursing home bed, they will fill it.

Michigan has a tough Certificate of Need law limiting the number of nursing home beds in each county. But in southwestern Michigan, no one has bothered to build the 123 beds for which a Certificate of Need permit would be readily issued.

Indeed, an additional 49 beds in one nursing home have been shut down for several years. And one 16-bed home just shut its doors. And all of this without a clamor for more beds.

And the impact goes beyond that. In addition, an early study by the Center for Social Research at Western Michigan University

found that clients in our program have fewer hospital visits, fewer emergency room visits, and fewer nonroutine physician visits.

So a final issue is, could the Nation afford to provide home-based long-term care to all at-risk persons with disabilities?

Well, it depends very much on how the system is structured. Some cost estimates range as high as \$56 billion and for good reason.

Based on the recent experience of Medicare home health services, expenditures under current procedures would reach that level by the turn of the century. In 1988, the Court in *Duggan v. Bowen*, the Court opened up eligibility for Medicare home health substantially. It blurred the distinction between acute recuperative care and chronic care. Today, chronic care patients may receive supportive services through the avenue of skilled care, even when the patient's condition is stable and expensive skilled care is unnecessary.

The Health Policy Center at Brandeis University studied the Health Care Financing Administration (HCFA) records of Medicare home health recipients and found that expenditures between 1988 and 1991 increased from \$2.1 billion to more than \$7 billion. While the expenditures more than tripled, the number of patients added were very modest.

The Policy Center points out that this home health benefit is supply-driven with demand determined by provider discretion. The Policy Center concluded that even if growth rates moderate, "expected charges may increase to \$18 billion by 1995 and could exceed \$65 billion by the end of the decade, outdistancing Medicare's payments to physicians."

And this is not a comprehensive program. Large numbers of Americans with disabilities would be left out even if the bank is broken.

And this is the final insight we would like to share with you. An efficient, effective home care system must separate recuperative care, which requires skilled care for therapeutic reasons, from supportive care, which may or may not include expensive skilled care.

In fact, in most cases some type of unskilled care may be far more beneficial to clients.

The Medicaid waiver project in Michigan uses primarily personal care rather than a medicalized model of home health. We may use skilled care when it is necessary and desirable and we are quick to admit clients to the medical system in the event of an acute care episode of medical instability.

An efficient, effective system, best for client as well as taxpayer, must be need-driven, not supply-driven.

This requires that the care be managed by a non-service providing agency without any vested interest in any particular service, driven by a purely focused interest in the welfare of the client; one that helps the client choose from the range of services in the marketplace and allows services to be drawn from a variety of sources and agencies in accordance with the client's best interest and with full consideration of quality.

Michigan's Medicare waiver program uses non-service provider agencies for its care management, usually Area Agencies on Aging.

If this model were extended to all nonwaivered eligible Americans with disabilities of all ages and if graduated co-pays for those

with incomes over \$15,000 annually were instituted, allowing for private insurance for wraparound coverage, according to our best estimates, it could be fully implemented through the Aging Network nationwide for between \$18 billion and \$23 billion, about a third of the projected costs of the Medicare home health.

And that does not count the savings that may be realized in other Medicare expenditures and in nursing home care. And keep in mind, no one would be denied appropriate medical care or skilled home nursing care.

It is no accident that in many States Medicaid waivers are operated by Area Agencies on Aging.

Over the last 20 years, the Aging Network has been putting in place mechanisms to carry out the home care system you are contemplating and is prepared to fulfill the mission of the Older Americans Act. It should not be ignored as a system to achieve solid efficiencies in long-term care.

By the year 2000, medical researchers, such as those in the National Institutes of Health, will find ways to address Alzheimer's disease and other types of dementia, find methods to control incontinence, discover medications to manage congestive heart failure, and reduce the number of strokes.

There will be spectacularly diminished necessity for nursing home admissions for persons with chronic diseases. And we must find ways now to address these extraordinary changes.

Can we afford it? Well, we still have one of the highest median household incomes in the world. And other nations with lesser resources seem to be able to address the problems of health and long-term care. Why can't we?

President George Bush in his Inaugural Address said, "We may not have the wallet, but we have the will." It appears that he may have had it wrong. We do have the wallet. It may be the will that is lacking.

Thank you.

Statement of

Robert Dolsen
Executive Director
Region IV Area Agency on Aging

I am Bob Dolsen, the Executive Director of the Region IV Area Agency on Aging, which serves Southwestern Michigan. And I thank you for the opportunity to share with you what we have learned in our eleven years of experiences with a home-based long term care system.

We have seen and heard from the media and from policymakers perspectives on long term care. Much of it is very disconcerting to us, since they have become part of the conventional wisdom and the premises on which the national debate about long term care is being waged.

I would like to address three of these issues:

- 1) Are great numbers of older persons becoming eligible for Medicaid by using trusts to "bury" their substantial assets for their children?
- 2) Can home-based services have an influence on nursing home occupancy and the use of medical services?
- 3) Can the nation afford a universal, community-based long term home care system?

These aren't new issues. Indeed, we had them in mind when we designed the model for our Care Management Project eleven years ago. We did an extensive literature search of home care models, including the Channeling Demonstration Grants of the late 1970s, and since then, as our system evolved into the Medicaid waiver, we have incorporated measures to address these issues, as have our colleagues in the four other Area Agencies on Aging who operate the state's other waiver sites.

Well, who are the older applicants in the Medicaid waiver program? They are not wealthy people using clever legal techniques to squirrel away their fortunes. These people are from the disintegrating middle class, persons with incomes under \$13,000 a year, with modest nest eggs they have accumulated over lifetimes, usually not exceeding \$20,000 or \$30,000, which they dutifully spend down before they become eligible for help.

The average age of our elderly clients is well over eighty (although over 20% of our clients are under 65). They are more often than not women, usually living alone. They come to us for help usually in a health crisis. Suffering a disability or an illness they had not anticipated, their shock is compounded when they learn that they must be impoverished to receive help. And why are they surprised? Because the securing of one's hard-earned savings in anticipation of a catastrophe is a well-established American principle. And when the costs of private insurance for that security outstrip an individual's ability to purchase, then policymakers establish public insurance programs to serve that purpose. It's the principle on which Medicare was based.

Those traumatized older persons erroneously assumed policy and program would follow that principle. Instead, the policy implies, "We don't want you to get away with spending any of your savings on a divorced daughter, or a son hit by a 'downsizing,' or a grandchild trying to get through school. Even though you've worked hard and contributed all your life and saved a bit as you were encouraged to do, we want that little bit you've put aside before we'll help you. And, oh yes, one more thing -- after you're gone, we're going to have your home sold so we can get that money back."

Those with whom we work are spared the third shock: that without the waiver in place, they would have had to go to a nursing home to receive any help. Without exception, they are most grateful for the opportunity to stay in their own homes. And they are most grateful to find teams of registered nurses and social workers expertly trained to explain their options and to carry out their choices.

But is this home-based waiver efficient, the preferences of disabled persons aside?

We realized at the outset that if we were to have a significant bearing on nursing home occupancy or the use of medical facilities, we would have to confine our efforts to those who truly needed those services. So we deliberately targeted our clientele very tightly, accepting only those "with multiple and complex needs" and waiting at the nursing home door. All our clients are certified to be medically appropriate for nursing home placement by the Michigan Department of Public Health.

And the impact has been profound. Michigan has a per capita nursing home rate slightly less than the average for the nation, and in Southwestern Michigan we have a rate 20% lower than the average for the state. We have laid to rest the notion that "if you build a nursing home bed, they will fill it." Michigan has a tough Certificate of Need law, limiting the number of nursing home beds in each county. But in Southwestern Michigan no one has bothered to build the 123 beds for which a Certificate of Need permit would be readily issued. Indeed, an additional forty-nine beds in one nursing home has been shut down for several years and a sixteen-bed home shut its doors. All this without a clamor for more beds.

But the impact goes beyond that. A early study by the Center for Social Research at Western Michigan University, using the classic control and experimental group model, found that clients in our program had fewer hospital visits, fewer emergency room visits, and fewer non-routine physician visits.

And because we are an Area Agency on Aging, we have been able to use to great advantage the Title III monies from the Older Americans Act to develop essential services where our Care Management client-tracking system shows us they exist: home repair, including ramps; respite care; financial services; etc. Currently, we are developing a program to send nurse practioners or retired physicians to the homes of very frail older persons who suffer from congestive heart failure, or influenza, or viral infections -- persons for whom a move to an emergency room or a doctor's office would be risky and expensive.

And, in all fourteen regions in Michigan, Area Agencies on Aging have been able to establish modest programs of Care Management for persons who don't quite meet the strict Medicaid financial eligibility but still have great need for long term care.

So the final issue is ... could the nation afford to provide home-based long term care to all at-risk persons with disabilities?

Again, it depends very much on how the system is structured. Some cost estimates range as high as \$56 billion. And for good reason. Based on the recent experience of Medicare home health services, expenditures under current procedures could reach that level by the turn of the century.

In 1988, the court in the *Duggan v. Bowen* case rendered a ruling requiring the Health Care Financing Administration (HCFA) to open up eligibility for Medicare home health care substantially. It has blurred the distinction between acute recuperative care and chronic care. Today, chronic care patients may receive supportive services through the avenue of skilled care -- even when the patient's condition is stable and expensive skilled care is unnecessary.

A study by The Health Policy Center, Brandeis University, and LifePlans, reveals that the consequence of this has been an explosion in Medicare home health expenditures. Under a grant from the Robert Wood Johnson Foundation, the Policy Center studied HCFA records of Medicare home health recipients and found that expenditures between 1988 and 1991 increased from \$2.1 billion to more than \$7 billion. While the expenditures more than tripled, numbers of patients added were modest, with the single most important component of the growth the average number of visits, accounting for 60.3% of the growth.

The Policy Center points out that this home health benefit is "supply driven," with demand determined by provider discretion. The Policy Center concluded that even if growth rates moderate, "expected charges may increase to \$18 billion by 1995 and could exceed \$65 billion by the end of the decade, outdistancing Medicare's payments to physicians."

This current Medicare home health system is not a comprehensive home care system. Large numbers of Americans with disabilities will be left out even when the bank is broken.

And this is the final insight we would like to share with you. An efficient, effective home care system must separate: recuperative care, which requires skilled care for therapeutic reasons, from supportive care, which may or may not include expensive skilled care. In fact, some type of unskilled care may be far more beneficial. The Medicaid waiver project in Michigan uses primarily personal care, rather than the medicalized model of home health, need it or not. We may use skilled care when it is necessary and desirable, and we are quick to admit clients to the medical system in the event of an acute care episode or medical instability.

And an efficient, effective system, best for client as well as taxpayer, must be need-driven, not supply-driven. This requires that the care be managed by a non-service providing agency without any vested interest in any particular service, driven by a purely focused interest in the welfare of the clients, one that helps the client choose from the range of services in the marketplace and allows services to be drawn from a variety of sources and agencies in

accordance with the client's best interests. This model also provides an excellent mechanism to establish across a range of diverse agencies and services quality improvement measures based on client outcomes.

Michigan's Medicaid waiver program uses non-service provider agencies for its care management, usually an Area Agency on Aging, and has adopted a social support model, tightly targeted toward those with multiple and complex needs. If this model were extended to all non-Waiver eligible Americans with disabilities -- of all ages -- and if graduated copays for those with incomes over \$15,000 annually, allowing for private insurance for "wrap-around" coverage, according to our best estimates, it could be fully implemented through the Aging Network nationwide for between \$18 billion and \$23 billion, about a third of the projected costs of Medicare home health -- with business as usual. And that does not count the savings that may be realized in other Medicare expenditures and in nursing home care.

It is no accident that in many states Medicaid waivers are operated by Area Agencies on Aging. The Older Americans Act in 1973 gave Area Agencies on Aging the charge to "establish comprehensive, coordinated systems of services at the regional, or substate level to keep older persons in their own home or places of residence as long as possible." For the last twenty years the Aging Network has been putting in place mechanisms to carry out the home care system you are contemplating, and is prepared to fulfill the mission of the Older Americans Act. It should not be ignored as a system to achieve solid efficiencies.

By the year 2000, medical researchers, such as those in the National Institutes on Health, will find ways to address Alzheimer's Disease and other types of dementia, find methods to control incontinence, discover medications to manage congestive heart failure, and reduce the numbers of strokes. There will be spectacularly diminished necessity for nursing home admissions for persons with chronic diseases. And we must find ways now to address these extraordinary changes.

Can we afford it? Well, we still have one of the highest median household incomes in the world. And other nations with lesser resources seem to be able to address the problems of health and long term care. Why can't we? President George Bush, in his Inaugural Address, said that "we may not have the wallet, but we have the will." It appears that he may have had it wrong. We do have the wallet. It may be the will that is lacking.

Reference: The Health Policy Center, Brandeis University & LifePlans, Inc., "Medicare Covered Home Health Services: The Struggle for Definition and Implications for Populations Served," Waltham, Massachusetts, 1993

NURSING HOME OCCUPANCY FOR AVAILABLE BEDS AND NEEDED BEDS MAY 1994

	AVBLE BEDS	% OCC. AVBLE BEDS	NEEDED (EXCESS) BEDS	1995 BED NEED	% OCC. 1995 NEED
Region 1-A DETROIT	6952	84.94%	(798)	6154	95.95%
Region 1-C WAYNE	5138	85.10%	(646)	4492	97.34%
Region 1-B LIVINGSTON	11484	88.32%	(116)	11368	89.23%
MACOMB	392	84.30%	56	448	73.76%
MONROE	3720	91.46%	(158)	3562	97.61%
OAKLAND	696	92.00%	(101)	595	107.62%
ST. CLAIR	4812	83.97%	273	5085	79.46%
WASHTENAW	722	94.32%	37	759	89.72%
	1142	85.30%	(223)	919	106.00%
Region 2 HILLSDALE	1565	97.61%	(112)	1453	105.14%
JACKSON	241	99.41%	0	241	99.41%
LENAWEE	827	97.24%	(94)	733	109.71%
	497	97.36%	(18)	479	101.02%
Region 3 BARRY	3154	91.03%	(679)	2475	116.01%
BRANCH	252	96.60%	(12)	240	101.43%
CALHOUN	283	92.38%	(58)	225	116.19%
KALAMAZOO	866	93.50%	(106)	760	106.54%
ST. JOSEPH	1384	89.12%	(464)	920	134.07%
	369	87.57%	(39)	330	97.92%
Region 4	1496	86.96%	127	1623	80.16%
BERRIEN	862	85.47%	74	936	78.71%
CASS	230	82.82%	54	284	67.07%
VAN BUREN	404	92.50%	(1)	403	92.73%
Region 5 GENESEE	2525	88.91%	(43)	2482	90.45%
LAPEER	1952	88.57%	(93)	1859	93.11%
SHIAWASEE	253	86.58%	42	295	74.34%
	320	92.14%	8	328	89.89%
Region 6 CLINTON	1805	89.09%	(223)	1582	101.65%
EATON	171	98.33%	50	221	76.47%
INGHAM	444	93.53%	(53)	391	106.21%
	1190	86.04%	(220)	970	105.55%
Region 7 BAY	4134	94.38%	(471)	3663	106.52%
CLARE	570	97.97%	38	608	91.85%
GLADWIN	200	96.43%	25	225	85.72%
GRATIOT	159	93.81%	23	182	81.95%
HURON	556	95.12%	(332)	224	236.10%
ISABELLA	313	95.48%	(35)	278	107.50%
MIDLAND	309	79.68%	(97)	212	116.11%
SAGINAW	414	97.11%	(93)	321	125.24%
SANILAC	1088	95.07%	(60)	1028	100.62%
TUSCOLA	247	95.89%	45	292	81.11%
	278	91.47%	15	293	86.79%

Region 8	4815	91.33%	(551)	4064	103.72%
ALLEGAN	565	88.32%	(124)	441	113.15%
IONIA	243	89.75%	4	247	88.30%
KENT	2819	90.50%	(620)	2199	116.02%
LAKE	117	96.15%	(17)	100	112.50%
MASON	202	95.40%	(8)	194	99.33%
MECOSTA	182	94.33%	17	199	86.27%
MONTCALM	188	97.80%	115	303	60.68%
NEWAYGO	245	95.16%	2	247	94.39%
OSCEOLA	54	97.88%	80	134	39.44%
Region 9	1574	87.38%	18	1592	86.39%
ALCONA	87	87.74%	26	113	67.55%
ALPENA	153	97.11%	35	188	79.03%
ARENAC	148	81.95%	(27)	121	100.24%
CHEBOYGAN	162	91.45%	(3)	159	93.18%
CRAWFORD	180	56.61%	(78)	82	110.46%
IOSCO	184	91.28%	33	217	77.40%
MONTMORENCY	75	89.92%	8	83	81.25%
OGEMAW	233	91.85%	(90)	143	149.66%
OSCODA	90	97.62%	(20)	70	125.51%
OTSEGO	154	85.62%	(53)	101	130.55%
PRESQUE ISLE	49	100.00%	59	108	45.37%
ROSCOMMON	79	91.45%	128	207	34.90%
Region 10	1650	91.38%	(281)	1369	110.14%
ANTRIM	113	99.49%	12	125	89.94%
BENZIE	84	97.96%	1	85	96.81%
CHARLEVOIX	73	96.80%	52	125	56.41%
EMMET	230	86.65%	(88)	142	140.35%
GR TRAVERSE	482	98.45%	(183)	299	158.71%
KALKASKA	68	95.59%	16	84	77.38%
LEELANAU	86	80.71%	18	102	68.05%
MANISTEE	221	80.74%	(53)	168	108.21%
MISSAUKEE	75	81.14%	(5)	70	86.94%
WEXFORD	218	89.45%	(49)	169	115.39%
Region 11	2542	96.40%	(453)	2089	117.31%
ALGER	106	69.31%	(41)	65	113.84%
BARAGA	87	100.00%	(20)	67	129.85%
CHIPPEWA	168	92.13%	5	173	89.47%
DELTA	292	99.28%	(60)	232	124.96%
DICKINSON	266	95.36%	(67)	189	129.16%
GOGEBIC	221	98.25%	(40)	181	119.96%
HOUGHTON	335	99.40%	(42)	293	113.65%
IRON	249	96.50%	(113)	136	176.68%
LUCE	61	97.10%	(25)	36	165.72%
MACKINAC	60	100.00%	17	77	77.92%
MARQUETTE	341	97.77%	(16)	325	102.58%
MENOMINEE	181	95.81%	(8)	173	100.24%
ONTONAGON	110	99.74%	(33)	77	142.49%
SCHOOLCRAFT	75	98.16%	(10)	65	114.07%
Region 14	2028	93.49%	(295)	1733	109.41%
MUSKOGON	945	93.48%	(109)	838	105.67%
OCEANA	113	96.08%	26	139	78.11%
OTTAWA	970	93.20%	(212)	758	119.27%
State	50662	89.46%	(4,523)	46139	98.22%

Senator RIEGLE. Thank you very much. Very good. And we appreciate that presentation. And now finally Dr. James O'Brien, who's here from Lansing, and I've mentioned before his important roles that he is presently involved in.

And we'd like to hear from you now, Doctor.

STATEMENT OF JAMES O'BRIEN, M.D., PROFESSOR AND ASSOCIATE CHAIR, DEPARTMENT OF FAMILY PRACTICE, MICHIGAN STATE UNIVERSITY; MEDICAL DIRECTOR, GERIATRICS, ST. LAWRENCE HOSPITAL; AND CHAIR, COMMITTEE ON AGING, MICHIGAN STATE MEDICAL SOCIETY

Dr. O'BRIEN. Thank you, Senator. I truly feel humbled and inadequate in the presence of some exceptional human beings.

It's a pleasure to be here and my presentation will be much less passionate and compelling than perhaps what we've heard, but I think perhaps equally important.

What I want to focus on really are some critical elements that I think should be in any new health care system. And such elements or values that perhaps emphasize function, independence, and autonomy for older adults, continuity, sensitivity to the particular needs of older adults, acknowledging the role of the family and finally integration of the social, personal, and medical needs in the provision of care.

This should be centered in a primary care type setting, which is the model that seems to be most successful in many other countries. I want to emphasize each of the elements and I'll try to be as quick and efficient as possible.

I think, in particular, physicians need to re-orient and be much more attentive to an individual's functional capacity, as this has such a profound effect on independence and autonomy.

For example, a list of chronic diseases tells us very little about the health of an older adult; whereas the loss of an ability to bathe or to dress may be of huge significance and makes that individual dependent on somebody else.

Many of these losses of function are not related to aging thus we need to understand that many of them may be amenable to treatment or to restoration.

A prime example occurs in hospital settings. Given the hazards of bed rest where an older adult who's at absolute bed rest, may lose 5 percent of their strength per day, we still mandate that people are at bed rest.

So I think that physicians and hospitals need to reorient and become part of the solution rather than part of the problem.

Autonomy. The autonomy of older adults should be valued. Decisions by the older adult regarding where to live, may be in conflict with family wishes, particularly if the decision imposes some risk, despite that those wishes need to be honored and supported and respected.

Similarly preferences regarding terminal care expressed through living wills or advance directives need to be honored, again, even if this is at odds with family wishes.

I think we witnessed this most recently when a former President, despite access to unlimited technology, chose to exercise an option that resulted in death with dignity.

I'm not antitreatment. I think when treatment can be helpful and restore function and independence, or provide comfort, it should be prescribed, despite age.

Continuity. Each older adult should have access to a primary care physician who provides first contact and ongoing care and who can coordinate care in an increasingly complex environment, so that over time an enduring relationship can develop.

Ideally, this should be in collaboration with other primary care practitioners, including advanced degree nurses, physicians' assistants, and social workers.

The next principle, sensitivity to aging. Given that a very limited number of physicians are pursuing training in geriatric care, we need to upgrade the skills of existing practitioners so that they're educated to the particular needs and problems of older adults. Traditionally this has not been taught in medical schools.

Physicians need to understand that oftentimes there's an exquisite sensitivity and vulnerability on the part of older adults to certain drugs and certain diagnostic tests that may, in fact, do more harm than good.

Continued and expanding research is needed especially with regard to the new technologies and their risk benefit to older adults. In the future, procedural, and attitudinal skills specific to older adults need to be incorporated in medical school, residency, and continuing education curricula for all physicians.

The role of the family, who are such an integral part in the success of any medical intervention, needs to be supported and supplemented. Families, when available need to be integral partners in providing care to older adults.

They need to be educated regarding the range, the potential and the limitations of health care services. Families providing essential care to older adults should be supported and encouraged.

We had a situation recently where this elderly couple, the wife who had Alzheimer's disease for 10 years, was totally dependent, was wheelchair bound, incapable of speech or feeding herself, et cetera.

Her husband provided round-the-clock care, and when he was diagnosed with prostate cancer he chose a treatment that would impose the least burden on his wife, so it would limit the time that he was in the hospital and away from her.

And you know, any additional services that had to be provided in his absence were out-of-pocket expenses. That's ridiculous.

Elder care. Finally, in terms of integration in a primary care system, elder care, given its complexity of medical, social, mental, and functional demands requires an integrated system. I think we heard that in the testimony this morning.

So we need a system that can respond to these multiple needs. If we base this in a primary care system with primary care physicians, but integrated with nursing, social work and then bolster it with specialty care, as we need our specialty care.

And I'm pro-specialty care, but we need specialty care coordination. This then could constitute a unit that could deliver acute, chronic, and expanded health care.

I was asked to comment briefly on managed care versus fee for service. You have to realize not all physicians are homogenous, so I may be representing a smaller group here.

But my sense is, this plan or a plan could be offered in a managed care model, but the entity would need to define its range of services that would and would not be offered.

Basic care for all, with an emphasis on prevention and quality of life, would be accorded the highest priority; whereas, futile and excessive care would be limited.

The older adult would be a partner in this endeavor in decision-making as well as participating in some form of payment via a co-pay but preferably this should be on a sliding scale. So for those that don't have it, there shouldn't be any payment.

Exemplary models of senior managed care programs should continue to be piloted. I don't think we have the model or an exceptional model yet, so we need to experiment, I think.

And then when we find successful models, we should disseminate that information. And perhaps social HMOs have the greatest potential to meet the broader health care needs of the elderly, but this would require much greater flexibility and funding.

The early retirees. We've already heard of the great need to provide some assistance to those individuals. Many of those individuals in my experience may have retired on lower incomes, and typically don't have health insurance, they may have retired for health reasons or may have retired to care for a spouse or a relative. They need immediate assistance and support.

A comment on Medicare. The system is inadequate in many respects, fails to cover payment for the prescription drugs—again, I don't want to be redundant—and oftentimes will cover expensive acute care services but then fail to provide the home care services that might either keep the person out of the hospital or allow them the opportunity for full recovery.

Medicare reimbursement for primary care physicians, given the complexity of the problems in that setting, is inadequate and therefore an impediment to access.

A comment about legal reform. In this new system, given that the emphasis is on partnership and collaboration, meaningful legal reform, or specifically malpractice reform needs to occur so that physicians feel less obligated to practice defensive medicine.

Such action is likely to benefit the older patient in particular, by lessening the risk from the unnecessary expense of and often hazardous diagnostic tests.

In closing, despite perceptions to the contrary, my sense is many physicians, particularly those in the trenches, want to be partners in effecting change and help create an exemplary system of care for older adults, which I think we are eminently capable of achieving in this country.

Thank you.

Senator RIEGLE. Thank you very much, Dr. O'Brien.

We're going to follow this plan for the remainder of the time we have together. We've covered a lot of ground. I must leave immediately to try to make this plane in Detroit to get back for this health care meeting in Washington later today.

I'm now going to call up two of my senior staff members, John Sciamanna, who is here from Washington who's assisting me on health care reform and Elizabeth Gertz who works in that capacity here in the State of Michigan.

And they will, over the period of maybe the next final 20 minutes here do this—allow any questions that any of you want to direct to any of our panelists who are still here.

To be able to do that, we'll have a period for that. And then if there's anybody else who has questions that they want to ask about the plans that are on the table, that you may have some confusion about, the Clinton plan, the other plans, both John and Elizabeth are in a position to try to respond to those questions.

I would say, again, anything else that you'd like a response to in writing, if you'd give me that with your mailing address, we'll respond to that.

I'm going to excuse myself now. We're going to conclude the hearing in about a half an hour, the way I've just described. Let me bring John and Elizabeth up now and thank you all as I must depart. Thank you.

Mr. SCIAMANNA. Are there any questions or would anybody wish to make.

SPECTATOR. Yes, sir. I just want to make a comment. I want to thank the Senator for having this meeting. I know all about this reform package. I have no questions. And I wish him a very safe trip back to Washington and "Give them hell, Harry."

Mr. SCIAMANNA. Well, we'll make sure we do that. Okay.

Senator RIEGLE. I caught that message.

Mr. SCIAMANNA. Are there other questions of the panelists or if we don't have those kind of questions, any questions on the health care issue itself or comments? Yes, over here.

SPECTATOR. I would just like to say that I hope that when this health care reform goes through, that attention is paid to the co-pays and things that people have to pay.

Because if you have a chronic illness in your family, the bills are astronomical and it's not our fault that they are, they just are. And not only with my child who's immune deficient, I have a father with lymphoma and his bills are starting to mount up also.

And if there's a co-pay on every procedure, every office visit, every whatever, I'm hoping that there's some type of a limit on that so that we can afford it.

Mr. SCIAMANNA. Okay. I should mention, too, that as you make comments, it's being taken down by the stenographer, so this will be part of the record, too.

Are there other comments or questions?

BILL GUTOS

Mr. GUTOS. Can you take a very general comment?

Mr. SCIAMANNA. Sure, Bill.

Mr. GUTOS. Mr. Sciamanna, we've heard a lot of good stuff here. I just hope that everyone is cognizant of the single payer that's starting to grow throughout the country.

But we know that Representative McDermott from the State of Washington, a physician/psychiatrist and Senator Wellstone from Minnesota are sponsoring that legislation.

I'm wondering if people in Michigan have heard that the State of Washington has put a single payer ballot in the State for November 8.

So with that and then also if you haven't had a chance to review the Consumer Report magazines for July, August, and September 1992, I wish all of us would take a look at that.

But again, I'm interested in getting everyone covered and the greatest savings to everyone. We know that the Budget Office and General Accounting Office both said that in the final wash, if we're going to get everyone covered at the greatest savings, we're going to have to go single payer.

So I have a question here that I'm going to give you so you won't lose it in Washington. And I want to thank everyone here. Thank you much.

Mr. SCIAMANNA. Okay. And I should say under the Clinton plan, States do have that option to provide single payers so we at least have that in the plan there and it's a key issue.

I think you might want to express that to your Congressman to make sure at least that stays in the plan that States have that option.

Mr. GUTOS. I hope you noticed that the Senior Power Day platform is endorsing a single payer approach for the State and the Nation. Thank you.

Mr. SCIAMANNA. We read that and so did the First Lady so—

Mr. GUTOS. I thank you.

Mr. SCIAMANNA. Any other comments or questions?

SPECTATOR. This thing about prescription drugs bothers me. The fact that drugs made in America can be sold cheaper other places. It kind of bothered me.

I'm wondering if we can't make some arrangements to buy our drugs from some company in Europe rather than buying here and get them cheaper. You know, it sounds crazy in a sense but it might make sense just the same.

Mr. SCIAMANNA. Well, some of those drugs that are being sold cheaper in other countries are being made here, too.

SPECTATOR. That's what I'm talking about.

Mr. SCIAMANNA. Yes, and that is a really big issue with the Chair of this Committee, the Aging Committee, Senator Pryor. The President, too, obviously has been very concerned about the prescription drug issue and the problems and he's used some of the bully pulpit, if you will, to kind of address that.

But that has also been a concern of the industry and being opposed to a national pharmaceutical program, because they're afraid that there will be some cost containment. Yes.

SPECTATOR. One more thing. I attended a meeting on health. I worked for a company for 35 years. They make a lot of medicine. This gentleman brought about made in the United States and you mentioned a lot of this is shipped over there.

If they can give drugs cheaper to those people over there, why can't they do it the same thing here?

I attended a meeting. There were three meetings in Midland, Michigan. And I worked for Dow Chemical Company. We make a lot of medicine. I mentioned to a lady—I don't know how—I didn't get her name—I probably will before it's over with.

But I mentioned to her, brought up a suggestion, a land of plenty, you want us to hold our medical at \$2,000. I got a big envelope of them. All these things, that goes back. A lot of retirees went there. I said okay.

I even told my president, "I don't mind bending my share, but let the other share"—this is what he is talking, "Let the big fat cats pay their share."

Okay. I said, "I'll hold it. Why not set up a—the most concentrated retirees is in the Midland, Saginaw, Bay City area from Dow and Dow Corning."

I says, "Why not? Now you're asking me to hold my line. You sell us generic drugs cheap, that our retirees from Dow and Dow Corning can go there and pick them up."

Well, they send us down to St. Louis, Missouri. I have a pocket—a card in my pocket express. And you pay more to send to get the medicine when if you could set up one right over there. She said. "That's a good suggestion." I just thought I'd throw that in.

Thank you, Mr. Chairman.

Ms. GALLANT. Would I be in order just to comment on the concern of the high cost of prescription drugs?

I would encourage everyone to continue to write their Senators and their Congressmen because each are not holding special meetings as Senator Riegle has seen fit to do.

So that is an option that you have, you know, not one card but just flood their offices with your concerns and one of prescription drugs is a very, very grave concern for most of us.

Dr. O'BRIEN. I'd just like to comment. I think there are many instances where there are less expensive alternatives to recommended drugs. I mean, generic drugs, certainly are acceptable substitutes in many instances.

But you know, given the competition in the pharmaceutical industry, even if the drug is not exactly similar, I would challenge your physician and say, you know, "Is there something comparable that perhaps is less expensive?"

I think in many instances physicians when they write a prescription are unaware of what it costs at the counter and I think they need to be educated.

Mr. ARNOLD. Sir, just to go along with his statement. The other side of that coin is, there are some highly specialized types of drugs that you're basically monopolized with whatever pharmaceutical in our case where, because of differences in production, they have a different effect on the patient that receives them. So you do not have that capability available.

Mr. SCIAMANNA. Yes.

SPECTATOR. I would like to say, I have this same immune deficiency that Debbie Arnold's son has. I am 32 and I look fairly healthy and look fairly healthy a lot of the time; however, my illness is life threatening. I have several other chronic illnesses.

I have been—I am blessed with Medicare. However, 20 percent of my Medicare bill every month comes to about \$300 to \$400, which is intolerable for me. I make \$580 under disability and am not functional enough to work all of the time.

With regard to medicines, I have three medicines, that my blood levels were so uncontrollable, given the generic, that I could not be

given those medicines because it became life threatening because I was toxic or I wasn't getting enough of it.

Again, Medicare doesn't cover my medicines. We're talking hundreds of dollars every month. I only make \$580.

So I would like it to go on the record, just as someone else said, that deductibles have to be addressed and that prescriptions have to be addressed. Thank you.

Mr. SCIAMANNA. All right. And if that's it, if you have anything you'd like to submit—One more?

SPECTATOR. I have a concern about Social Security disability. I have applied and been denied twice. I have a person I know in another State who has applied and was not in Michigan allowed or determined to be disabled.

When she moved to another State, she was disabled. She has many less disabilities than I do. Is it a State by State issue, disability, a determination? It appears to be to me.

Mr. SCIAMANNA. It's not supposed to be. It's run by the individual States and there's been a number of problems on that whole issue. And the Social Security Administration is now trying to implement a new process that will speed it up and hopefully help people like you.

It probably took you, what, a couple years to go through just——

SPECTATOR. I'm still going through it.

Mr. SCIAMANNA. You're still going through it?

SPECTATOR. Yes. And it seems as though they're not knowledgeable about a lot of chronic illnesses, which we are working hard to inform them as to our limitations and the cost factors involved.

Ms. GERTZ. You should be aware, too, that you should call our office because Senator Riegle does make inquiries on individual cases of people who are in the appeals process for Social Security disability, so certainly give us a call.

Debbie has our number or get it from me. I'll give you our card and we can at least follow your process.

SPECTATOR. Thanks so much.

Mr. SCIAMANNA. Okay. If no other comments, then you can submit anything you have in writing and we'll be glad to get an answer for you.

Thank you for coming.

[Whereupon, at 12:45 p.m., the Committee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

SENIOR POWER DAY PLATFORM

RESOLUTION—NATIONAL HEALTH CARE REFORM

Whereas, Over the next two years, one out of four Americans will be without health coverage at some point, and there are currently over 34 million without coverage in the U.S., of which 5 million are children; there are 1 million without coverage in Michigan, of which 300,000 are children; and

Whereas, Today's system discriminated against families and small businesses. Insurance companies pick and choose whom they cover. Those with pre-existing conditions can't get any insurance at all; and

Whereas, Only 20% of Americans over 55 can afford long-term care insurance; and only 16% of those age 65–79 can afford long-term care insurance; and

Whereas, The cost of lifesaving prescription drugs has been rising faster than any other component of medical price index, and over half of those 65+, and one-quarter of those under 65, must pay for prescription drugs on their own; and

Whereas, Insurance companies charge small businesses as much as 35% more than large corporations. Only 3 of every 10 employers with fewer than 500 employees offer any choice of health plan. Millions of Americans have no choice today; and

Whereas, 25 cents out of every dollar of a hospital bill goes to bureaucracy and paperwork—not patient care; and

Whereas, fraud and abuse are exploding, costing at least \$80 billion a year. That's a dime of every dollar spent on health care; and

Whereas, Our nation's health costs have nearly quadrupled since 1980. Without reform, by the year 2000, one of every 5 dollars spent in America will go to health care; therefore be it

Resolved, That the federal government must guarantee that all individuals have access to affordable, high-quality health and long-term care; and be it further

Resolved, That a plan be developed which includes: System-wide cost containment that eliminates cost-shifting and slows the explosive growth in health spending; and Comprehensive benefits that include preventive and mental health care, prescription drugs, home and community-based long term care, nursing home care; and Health delivery reforms that increase access to care in underserved areas and reward efficient, high-quality care; and be it further

Resolved, That Senior Power Day supports the six principles of President Clinton's HEALTH SECURITY proposal: Security, Simplicity, Savings, Choice, Quality, and Responsibility; and, be it finally

Resolved, That a single payer approach for the state and nation be enacted in 1994 with broad-based, fair and affordable financing, so that government, businesses, and individuals all pay their share and everyone is protected against the high cost of care.

RESOLUTION—NURSING HOMES

Whereas, There have been notable improvements in the quality of life and care in nursing homes in recent years through the efforts of committed nursing home owners and staff, state regulatory agencies and better federal minimum standards; and

Whereas, 50,000 people are living in Michigan's 450 nursing homes, county medical care facilities and hospital long-term care units and should be treated with dignity and respect by all; and

Whereas, 43% of the people who became 65 in 1990 will need nursing home care; and

Whereas, Many people have difficulty in finding quality nursing home care in their community because they do not have the money to pay for care for as much as three years; and

Whereas, Some nursing homes refuse to fully participate in the Medicaid program and attempt to evict residents once their money is gone; and

Whereas, Michigan nursing homes earn about \$1.2 billion a year including some \$800 million from the Medicaid program; and

Whereas, The quality of nursing home care is dependent on the number of staff members providing care; and

Whereas, the staffing requirements in Michigan nursing homes have not changed since 1978; and

Whereas, Some homes do not meet minimum standards of quality; and

Whereas, The measure of a great society is how it cares for its weakest citizens and how it regulates service providers to insure the highest quality of care and services; therefore be it

Resolved, That Senior Power Day supports state policy changes to require every nursing home which participates in Medicaid to open all of its beds to Medicaid certification; and be it further

Resolved, That Senior Power Day supports state legislation to require that nursing homes admit people from a single list of applicants on a first-come, first-serve basis without regard to the applicant's wealth; and be it further

Resolved, That Senior Power Day supports state policy changes and implementation of a system of sanctions to ensure that nursing homes comply with government standards. These sanctions should include fines which increase with severity and repetition, bans on admissions, monitors to evaluate performance, temporary managers or receivers to operate a home, and transfer of the home to owners capable of operating it according to governmental standards. Closing or terminating governmental funding of a home should only be used as a last resort; and be it finally

Resolved, That Senior Power Day supports the enactment of proposed state legislation to increase the number of nursing care staff in nursing homes.

RESOLUTION—IN-HOME HEALTH CARE SERVICES

Whereas, The aged and disabled largely prefer the comforts of home to any health care or residential facility; and

Whereas, This state has developed and implemented two programs, care management and a Medicaid home care waiver program, which assist aged and disabled people to live independently and safely in their own homes and apartments; and

Whereas, The care management and Medicaid waiver programs insure that aged and disabled people have personal health care needs met as well as home delivered meals and a clean, comfortable living environment with home-cleaning and home-maintenance assistance; and

Whereas, These two programs also address the needs of family care givers with respite services and other supports so as to continue family caregiving; and

Whereas, These two programs of in-home health care services are a necessary part of a full, efficient and human health and human services delivery system which guarantees options to the aged and disabled and their families; and

Whereas, Care management is available in only 57 out of 83 counties, and the waiver program serves the aged and disabled residents of only 13 counties; therefore be it

Resolved, That the care management and Medicaid waiver programs must be expanded statewide to secure the complete range of health care options.

RESOLUTION—HOME-DELIVERED MEALS

Whereas, Nutritionally balanced meals are vital to good health; and

Whereas, There are 201 Michigan municipalities (counties, cities, townships, villages) or parts of municipalities that do not have some delivered meals; and

Whereas, It is estimated that 1/3 of the current home delivered meal clients need an additional meal daily; and

Whereas, Although the 1994 increase in funding for home delivered meals are a step in the right direction, state and federal funds have not kept pace with increasing demand and increasing costs; therefore be it

Resolved, That home delivered meal funding be increased by \$5.5 million to meet the needs of these municipalities and clients. We call on both the state and federal governments to appropriate the funding for these meal services.

RESOLUTION—TRANSPORTATION

Whereas, Accessible and affordable transportation is necessary for promotion of an independent lifestyle for all, so that individuals can meet their health, financial and social needs; and

Whereas, Agencies and all levels of government who provide some transportation services and in particular special transportation services need to coordinate those services in order to most effectively utilize taxpayer dollars; and

Whereas, Transportation has become cost prohibitive for the older citizen of low income status who must depend on public or volunteer services; therefore, be it

Resolved, That the Michigan Legislature and the Governor approve an additional \$1 million for specialized services for the elderly and handicapped in the budget of the Department of Transportation, to be used to expand those cost-effective programs that use volunteer drivers; and be it finally

Resolved, That all agencies and all levels of government that have monies for transportation coordinate all services so that the maximum number of rides can be available at the lowest possible cost.

RESOLUTION—AUTO INSURANCE REFORM

Whereas, It is a necessity for most Michigan residents to drive a car in order to keep a job and to carry out daily activities; and

Whereas, Every vehicle registered to a resident of Michigan is required to maintain certain automobile insurance coverage by law; and

Whereas, Most Michigan residents find it necessary to borrow money in order to buy a car and therefore are required to buy additional comprehensive and collision auto insurance; and

Whereas, Michigan citizens have little or no negotiating power as to insurance costs; and

Whereas, Public Act 143 of 1993 shifts cost of injuries to Medicaid and encourages people to be under-insured and therefore shifts costs of their negligence to the public; and

Whereas, Public Act 143 does not include enough regulation and control to insure that rates will drop so that all citizens are able to purchase auto insurance; and

Whereas, Public Act 143 was not subject to citizen petition and vote; therefore be it

Resolved, That we, as citizens of the State of Michigan, are entitled to responsible representation by our elected officials under the State Constitution of 1963 and formally protest the Legislature's passage and the Governor's endorsement of Public Act 143; and be it further

Resolved, That we are in favor of all legal efforts to repeal Public Act 143; and be it finally

Resolved, That we request that the Michigan Legislature immediately enact new auto insurance reform legislation which negates Public Act 143, retains consumer rights and benefits, lowers premiums through accountability and sound regulation of auto insurers, and eliminates "redlining" and other violations of the Constitution from the Michigan auto insurance system.

RESOLUTION—HOUSING

Whereas, Housing needs change with age, particularly for older women who are more likely to live alone, live in poverty and live with age-related disabilities; and

Whereas, Housing for the elderly must be affordable, given that 60% of the single female-headed, households and 20% of households headed by a single men and couples have incomes under \$10,000; and

Whereas, Housing for the elderly must be accessible as a majority of older adults prefer to live out their years in their own homes; homes made user-friendly to accommodate a burgeoning of chronic diseases common to aging (i.e., ramped stairs, grab bars near toilets and tubs, non-slip surfaces); and

Whereas, Seniors must live in an environment secure from crime and near medical care, public transportation and shops to remain independent in the community; and

Whereas, Housing policy has multiple layers of authority and responsibility—federal, state, county and city—with a mix of statutes, codes, regulations and practices; therefore be it

Resolved, That Senior Power Day urges support for:

A renewed federal and continued state commitment to new construction as well as maintenance of existing public housing. President Clinton's proposed 1995 budget would cut \$1 billion from the Section 202 housing program. This would reduce the annual production of subsidized housing by 87% from 9,000 units to 1,156 units;

An affordable continuum of housing alternatives to meet diverse needs and provide choice (i.e., shared housing, subsidized housing, assisted living);

A strengthened community-based support system in anticipation of implementation of national health proposals;

Public and private financing mechanisms for weatherization, home repair and renovation programs;

Increased local involvement in implementing neighborhood watch and related programs;

Awareness programs aimed at utility companies, post offices and other agencies who routinely call on seniors to serve as a support to those in need of help; and

Ongoing information exchange between the aging community and managers of housing developments.

RESOLUTION—COST OF UTILITIES

Whereas, Utility costs comprise a significant portion of average consumers' expenditures, and of older consumers' spending in particular; and

Whereas, Older Americans are particularly vulnerable to rapid increases in energy prices, often forcing such households to make choices among basic necessities; and

Whereas, The Michigan Public Service Commission is mandated to protect the interests of all customers, the State legislature must continue to monitor this body to ensure that the interests of all consumers, especially residential consumers, are well represented; therefore, be it

Resolved, That the Michigan Public Service Commission continue to:

Devise rate structures which provide stable revenues, reflect private and social benefits, distribute costs among customer classes fairly, are not unduly discriminatory, and are simple to understand;

Devise cost allocation methods which appropriately assign investment costs and accelerated depreciation expenses to service categories responsible for these costs and expenses; and be it further

Resolved, That the federal government restore at least its past funding commitment to energy assistance programs. Under the 1995 Clinton budget, the Low-Income Home Energy Assistance Program (LIHEAP) would be cut in half—from \$1.5 billion to \$730 million; and be it further

Resolved, That residential consumer rights be protected at Public Service Commission rate hearings; and be it finally

Resolved, That the government ensures essential utility services, including heat, light, water, power and communication services, are affordable for all households.

RESOLUTION—LIFE-LONG LEARNING

Whereas, All Michiganians describe life-long educational opportunities and are entitled to a quality education which can only be attained with adequate funding; and

Whereas, Continuing education throughout life promotes better physical and mental health for persons of all ages, and improves everyone's quality of life in the community; and

Whereas, Intergenerational programs promote life-long learning by bringing children and older adults together to enrich education and benefit both age groups; and

Whereas, Life-long learning by older adults promotes community involvement and volunteerism; and

Whereas, Life-long learning programs also help to utilize and mobilize local resources to effectively meet other senior needs such as civic information, nutrition and socialization; and

Whereas, Higher education alone does not meet all of the learning needs of most older adults; therefore be it

Resolved, That the Michigan educational system assess the prevalence, and attack the problem, of illiteracy. Additionally, there should be support for the use of older persons as paid employees and volunteers in intergenerational literacy training programs; and be it further

Resolved, That the Michigan educational system increase learning opportunities for older persons (credit, noncredit and part-time) at community colleges, technical and vocational schools, and other institutions of higher education, including student financial aid for qualified older persons, the ability to audit courses, and public information programs that alert older persons to the availability of such opportunities; and be it finally

Resolved, That life-long educational opportunities under the heading of community education be adequately funded and provided for the older adult learner in their neighborhoods and communities thereby providing accessibility and familiarity.

OTHER ISSUES

LIVING WILLS

While Michigan has enacted a law for durable power of attorney for healthy care, it does not have a living will statute. Therefore, living wills have no legal standing in Michigan.

A living will is a signed, dated and witnessed document which permits an individual to authorize in advance the withholding or withdrawal of artificial life-support measures in the event of terminal illness or injury.

With a durable power of attorney for health care, individuals appoint someone they trust to make decisions on their behalf. With a living will, individuals state what type(s) of treatment they want or do not want in the event of becoming unable to express their wishes. With a living will, however, individuals do not appoint someone to make those decisions for them.

We believe that competent adults have a fundamental right to control decisions relating to their own health care. We urge the state legislature to:

Enact legislation which recognizes the right of a person to make a written declaration instructing his or her physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition, thus legalizing a living will; and

Approve a state mandated living will form which clearly spells out all options available to a person.

INCREASED FUNDING FOR THE MICHIGAN EMERGENCY PHARMACEUTICAL PROGRAM FOR SENIORS (MEPPS)

We urge the legislature and Governor Engler to provide additional state funds in the fiscal year 1995 budget for the Michigan Emergency Pharmaceutical Program for Seniors, which has not seen an increase for several years. As of February 1994 there was a waiting list of over 4,000 low-income seniors who need drugs but are unable to get MEPPS vouchers.

PRESERVING THE RIGHT TO PRIVACY

We recognize the effect of changing technologies on the daily lives of our citizens. We are especially concerned with the possibility of invasion of privacy inherent in the indiscriminate use of these technologies. We advocate for the preservation of the right of privacy.

Adopted March 4, 1994.



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